mother. She would wonder whether the system we created is fair. And she would be right; it probably would not be fair.

What do we try to do about this? It is not perfect, but I think it is a major effort, and I think it is a good effort.

First, all Medicare beneficiaries who are enrolled in the new drug program will be combined for purposes of calculating premiums and payments to plans, regardless of whether those beneficiaries are in fee for service, enrolled in a drug-only plan, or whether they are enrolled in a private PPO or HMO. All senior citizens who are enrolled in Medicare will be combined for the purposes of calculating premiums and payments to plans, regardless.

Mr. ALLEN. Mr. President, will my good colleague from the State of Montana please yield for the purpose of an introduction of an esteemed guest? I know this is very important, but I ask if he will yield for a moment.

Mr. BAUCUS. Mr. President, I yield 1 minute to the Senator from Virginia.

The PRESIDING OFFICER. The Senator from Virginia.

VISIT TO THE SENATE BY THE HONORABLE PATRICK COX, PRESIDENT OF THE EUROPEAN PARLIAMENT

Mr. ALLEN. I thank the Senator because I know he is talking about a very important issue to all the people of America.

I do have the honor of presenting to my Senate colleagues the Honorable Patrick Cox, who is the President of the European Parliament. As my colleagues know, the European Parliament is the only directly elected body in the European Union and the only popularly elected international assembly in the entire world.

Every 5 years, Europe's 375 million citizens have the chance to vote for 626 representatives. President Cox's position is the equivalent of the Speaker of the House and the President of the Senate combined. So he is TED STEVENS and DENNY HASTERT together.

I appreciate the indulgence of the Senator from Montana, and I request my colleagues to take a moment to introduce themselves to President Cox because we do have so many transatlantic bonds, not only philosophically but also economically for jobs.

I yield the floor.

Mr. BAUCUS. We are very honored to have our guest. I don't know how long he wants to stay. There are so many transatlantic issues we can address.

I see my very good colleague from Iowa in the Chamber, and we have lots of agricultural issues. We would also like to learn from Europe about European health care systems. I am sure there are provisions in Europe we could look at and adopt. No country has a monopoly on good ideas and no region of the country has a monopoly on good ideas.

I urge our guest to stay as long as he possibly can and hopefully have time to converse over some of these issues so we can get a better idea of how we can resolve some of these huge issues, including agricultural and other trade issues. We all know the more we work together, the better we will be on both sides of the Atlantic.

Mr. ALLEN. Thank you, Mr. President.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—CONTINUED

Mr. BAUCUS. I have been explaining various provisions in the bill that I think largely address concerns that some on the Democrat side have and I suppose on the Republican side of the aisle, too; namely, potential premium variation. Premiums that seniors pay might vary. Much confusion might occur for seniors and anyone else involved in prescription drug benefits that would be distributed under this legislation.

As I mentioned, the actuaries say there should not be much change. Also, the risk pool will include all Medicare beneficiaries, ensuring an adequate number of low-drug-cost beneficiaries will be able to subsidize the few beneficiaries with the high drug costs. Already, there is a huge risk pool. There is kind of a cross subsidization. Those with very low drug costs will help pay for those much higher costs of other seniors. The larger risk pool will prevent premium variation because we use the whole pool.

In addition, the bill will calculate Federal contributions toward plan premiums based on the national average of all plan bids. This contribution is then adjusted geographically for differences in prices. This is a so-called geographic adjustor. We want to make sure one part of the country is not discriminated against compared to another part of the country or vice versa, and we included the geographic adjustment on prices.

We have not included so far, because it is difficult to calculate, geographic adjustment based on utilization. As we know, in some parts of the country there is more utilization. That is a fancy term for saying there is a lot more care given to people than in other parts of the country. More care, the greater utilization, tends to be in parts of the country with more hospitals, more specialty health care providers.

There is an interesting study I urge my colleagues to read by Dr. Wennberg. I have not found anyone who refutes it. Looking at the country as a whole, there are parts of the country where utilization is twice as high and more than twice as high as other parts of the country. People, because of where they live, get twice as much health care in some parts of the country than in other parts of the country. This is adjusted for age, for race, for gender. It is adjusted for all the factors that can possibly be thought of.

The more interesting part of this study, even though some parts of the country get twice as much health care as other parts of the country—and it is because there are twice as many doctors or hospitals in some parts of the country as in others—the interesting part of the study is, the actual care given is no better, and in fact in some cases it is worse. That is, if you get twice as much health care, that is, twice as many visits to the doctor or the hospital, particularly for chronic diseases, you will not be twice as healthy; you will not be any healthier, on average, than you will be in parts of the country where there is less utilization.

The point is that we are trying to adjust, as I mentioned earlier, and have a geographic adjustment based on the costs. We have not yet figured out a way to adjust for different utilization mainly because, when it comes to prescription drug benefits for seniors, there is virtually no data because we have not had prescription drug benefits for seniors yet. Obviously, it is hard to get the data if we have not had the program.

There are other provisions in the bill that enable us to get more data, so fairly quickly we can get better utilization data and therefore have a geographic adjustment based not only on price but also on utilization. That will go a long way to address some of the concerns people have about potential premium variation and complexity. When we get that data, as I said, we will have a lot more information, but there is enough information already to have the effect of minimizing concern about premium variations.

There is another provision in the bill to help address this potential problem. That is, we have included in this bill a provision based on the Federal Employees Health Benefits Program—otherwise known as FEHBP—that prohibits plans from changing premiums that are unreasonably higher than the costs of the benefits provider. In other words, plans are prohibited from price gouging. That standard currently is in the law with respect to the FEHBP plan. That is in the law. There is a provision in current law that prohibits the FEHBP plans from charging premiums that are unreasonably higher than the cost that has been provided. I believe that same provision as applied to prescription drug pricing is an additional guarantee against gouging and certainly against unconscionable premium variation.

Finally, this bill allows the Secretary to refuse to contract with the plan. That is in the bill. Maybe a plan leans toward enrolling healthier beneficiaries. Maybe the Secretary determines that this plan is not a good actor; this plan is price gouging; this plan is engaging in cherrypicking; it is engaging in adverse selection at the expense of an American; or maybe it seems less committed to staying in the program; maybe there is a shady operation; who knows, maybe it seems more likely to drop out fairly quickly

and it is not solvent or financially healthy; maybe the premiums seem inconsistent with others in the region.

For any of these reasons and reasons not contemplated at this time, the Secretary can decide, at his discretion, not to contract with a drug plan that has submitted a bid to participate in Medicare. That option is still there as a protection for our senior citizens. It is my hope that this discretion will help assure better plan choices for seniors and the benefits and premiums will, in fact, be fair and reasonable.

In short, in developing this compromise bill, Senator GRASSLEY and I have tried to allow a level of variation in premiums and benefits so as to foster innovation and to foster efficiency but not so much variation that seniors will be confused or plans will game the system.

I think we have done a pretty good job of ending confusion and a pretty good job of preventing plans from gaming the system. I hope my colleagues will agree this proposal strikes at that.

Madam President, I yield the floor.

AMENDMENT NO. 1040

(Purpose: To provide for equitable reimbursement rates in 2004 and 2005 for Medicare+Choice organizations making the transition to MedicareAdvantage organizations)

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Madam President, the Senator from New York, Mr. SCHUMER, and I are in the Chamber now to offer a amendment. Unfortunately, I have to withdraw that amendment because of budgetary constraints with which we are going to be dealing.

This is an amendment that we believe is critically important as a bridge from where we are right now on the Medicare Program to where this bill takes us. The bridge is in the area of Medicare+Choice, which is the Medicare option that is available in certain counties in this country for a health maintenance organization, the only place in Medicare that provides prescription drug coverage today.

About 10 to 12 percent of beneficiaries under Medicare participate in Medicare+Choice or Medicare HMO programs. Their satisfaction rate is as high or higher than in the traditional Medicare Program. The problem with Medicare+Choice or the Medicare HMOs is they are funded at a level which does not increase at the same rate that the Medicare Program increases. They are held at an artificially low level, which makes it very difficult for them to survive.

The concern of Senator SCHUMER, who has been a great leader on this issue, and my concern is what happens between now and 2006 when the new MedicareAdvantage Program comes into effect under this bill. That program will include Medicare+Choice or Medicare HMOs, and a new option that will be available through this bill of a PPO, which is a more lightly managed insurance. Medicare HMOs are heavily managed with gatekeepers and a restricted number of providers, both doctors and hospitals to which you have access, but you get more benefits. PPOs have less restrictions, less management, and more choices. The fee-for-service has no restrictions, maximum choices, but higher costs.

What we wanted to do is put in an amendment that gave us a bridge of funding so these existing HMO plans can survive until we get to 2006, because there is a big concern. We have seen HMO plan after HMO plan go out of business because of inadequate funding. Through the work of Senator SCHUMER and several others in this Chamber, we have been pushing this issue in the Senate. We ran into a roadblock because of the unavailability of funds in the Senate bill. But there is money in the House bill, and the amendment Senator SCHUMER is going to offer here, as soon as I drop the mike, will mirror what the House bill does.

I will turn it over to my colleague from New York. This is a vitally important amendment. It is really important for us to come out of the conference with money for Medicare+Choice or Medicare HMO plans for the years 2004 and 2005, so when 2006 rolls around we will have a viable program, a robust program that this new MedicareAdvantage Program can intersect.

If we, on our side of the aisle, are concerned about competition and choices and if we want choices, then we have to fund those choices to get to 2006, when, candidly, there will be a lot more money for these programs to survive. I would like to see them survive in the interim.

The Senator from New York, as I said before, is leading the charge on this issue. The House, thankfully, has included it in their underlying bill. We hope we will be able to keep that in conference.

I yield the floor.

The PRESIDING OFFICER. The Senator from New York.

Mr. SCHUMER. Madam President, I ask unanimous consent to set aside pending amendments and call up amendment No. 1040.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from New York [Mr. SCHUMER], for himself, Mr. SANTORUM, Mr. CORZINE, Mrs. CLINTON, Mr. LAUTENBERG, and Mr. KERRY, proposes an amendment numbered 1040.

Mr. SCHUMER. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide for equitable reimbursement rates in 2004 and 2005 for Medicare+Choice organizations making the transition to MedicareAdvantage organizations)

On page 294, line 6, strike ''or (C)'' and insert ''(C), or (D)''.

On page 294, line 21, insert ''(other than in 2004 and 2005)'' after ''multiplied''.

On page 297, strike lines 5 through 9, and insert the following:

''(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(v) For 2004 and 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(D) ANNUAL FEE-FOR-SERVICE COSTS IN 2004 AND 2005.—For 2004 and 2005, the adjusted average per capita cost for the year, as determined under section 1876(a)(4) for the Medicare+Choice payment area for items and services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B and not enrolled in a Medicare+Choice plan under this part for the year, except that such amount shall be adjusted—

''(i) to exclude costs attributable to payment adjustments described in subsection (a)(5)(B)(ii), and

''(ii) to include an amount equal to the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

On page 298, line 10, strike ''subparagraph (B)'' and insert ''subparagraphs (B) and (E)''.

On page 301, between lines 8 and 9, insert the following:

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for 2004 and 2005, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

On page 302, line 23, insert ''(or, in the case of calculations for payments for months beginning on or after January 1, 2004, and before December 31, 2005, the average number of medicare beneficiaries enrolled in a Medicare+Choice plan that are)'' after ''medicare beneficiaries''.

On page 303, line 9, insert ''other than 2004 and 2005'' after ''for each year''.

On page 349, between lines 4 and 5, insert the following:

(3) PAYMENT RATES BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS IN 2004 AND 2005.—

(A) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(i) in paragraph (1)(A), in the flush matter following clause (ii), by inserting ''(other than in 2004 and 2005)'' after ''multiplied''; and

(ii) in paragraph (5), by inserting ''other than 2004 and 2005'' after ''for each year''.

(B) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (E)''; and

(B) by adding at the end the following new subparagraph:

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for 2004 and 2005, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(C) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)) is amended by inserting ''(or, in the case of calculations for payments for months beginning on or after January 1, 2004, and before December 31, 2005, the average number of medicare beneficiaries enrolled in a Medicare+Choice plan that are)'' after ''medicare beneficiaries''.

(D) UPDATE IN MINIMUM PERCENTAGE INCREASE.—Section 1853(c)(1)(C) (42 U.S.C. 1395w–23(c)(1)(C)) is amended by striking clause (iv) and inserting the following new clauses:

''(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(v) For 2004 and 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.''.

Mr. SCHUMER. Madam President, I offer this amendment on behalf of myself and my colleague from Pennsylvania, as the lead sponsors of this amendment. I also ask Senators CORZINE, CLINTON, LAUTENBERG, and KERRY be added as cosponsors who support what we are doing here.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SCHUMER. Madam President, Senator SANTORUM has summed this up very well. We have a large number of senior citizens who have opted into a Medicare+Choice Program. The Medicare+Choice Program has been an experiment. Basically it said, let's let some providers, in this case HMOs, provide Medicare for senior citizens so they have an option to go into it.

What most of these programs have done, frankly, is they made a sort of deal with senior citizens. They say you have to go to the doctors and hospitals that are a part of our plan. In that way, we will reduce costs. Then we can provide prescription drug coverage or other types of coverage for you. It has been quite popular in a good number of places, in my State as well as many other States.

This program has had some trouble, there is no question about it. The reason is the cost of prescription drugs has gone way up. Health care costs have gone way up. As a result, many have pulled out of Medicare+Choice. Many seniors—not all but most of the seniors I know—went into it so they could get some prescription drug coverage.

I agree completely with Senator SANTORUM. We are, in 2006, going to provide all kinds of different help to private providers who will provide either prescription drug coverage or a whole Medicare+Choice-type situation. But it absolutely makes no sense to let these programs go under, which they will because there is not enough money for them now, in 2004, 2005, until 2006 funding kicks in, and then whole new infrastructures would have to be set up.

In addition, the premiums have gotten so high because the costs have gotten high and we have been unable to put in the money that many of those providing Medicare+Choice have either pulled out entirely of large regions in this country or so many have pulled out there is not the competition we would like to see.

In Suffolk County, in my area, I think it is 80,000 senior citizens who were in Medicare+Choice; but where there were once 6 providers, there are now only 2.

In addition, and really galling to the seniors, with good reason—I completely agree with them—the premiums, the copayments on these programs have been large. They once were $10 or $20 or $30. Now, particularly in suburban areas, they are $140 to $170 a month. In fact, many of my constituents, with justification, cannot understand why Medicare+Choice is available in some areas with no copayments and no premiums, and in others the premium is so high that if you are a typical senior citizen on a fixed income, you can't afford it.

Our proposal does two things—and, again, Senator SANTORUM is exactly correct. No. 1, it provides the money so these programs can stay in effect until 2006. Once we get to 2006, they are taken care of because of the structure of this bill. But to have them collapse makes no sense.

Second, it provides some equity. Because costs are higher, for instance, in Suffolk and Nassau Counties, they should not be treated the same and given the same dollars as New York City.

Who is paying the higher costs in the end? The senior citizen who is having the same kind of expenses as a senior citizen in New York City.

We add just the formula and make it more flexible so high-cost areas get some reimbursement. This is a problem in the suburbs of New York, in the suburbs of Philadelphia, in the suburbs of Texas and California. It tends to be a suburban problem.

But make no mistake about it: Many of the senior citizens who live in these suburban communities are not wealthy. They are not middle class. They are struggling. They are on a fixed income. Medicare+Choice originally was a salvation to them. Now it is becoming a real burden.

I would add, I do not believe this is the fault of the HMOs providing the service. It is the Federal Government that has not put in enough money to make these things viable. We have corrected this in this proposal, but only in 2006, when it takes effect. Again, it makes no sense, no sense whatsoever, to let these HMOs that do Medicare+Choice fold and then have to start up again.

So this is an important amendment. Unfortunately, we cannot bring it to a vote because in the rules of the Senate, we would have to get 60 votes to adopt this, and that is too uphill a burden. But the good news is, it is in the House bill which has different rules.

I know Senator SANTORUM, as well as all my cosponsors, joins me in saying we want this program to be put in the final bill when it comes out of conference committee. We know there will be the kind of dollars that might be available, and this is an extremely high priority.

So I am offering this amendment to underscore that importance, to let our diligent leaders of the Finance Committee—Senator GRASSLEY and Senator BAUCUS—know how important it is to a good number of us, and to make sure it has its place at the table when the conference committee occurs.

I just want to make a few more points about Medicare+Choice Programs. These do not benefit well-to-do people. Let me give you some numbers. Among Medicare beneficiaries who have annual incomes between $10,000 and $20,000 and who do not have Medicaid or group health coverage, 40 percent are in Medicare+Choice. These are the very people who cannot afford the high cost of prescription medicines.

Medicare+Choice, when it came in, was a godsend to them. And I, for one, am on this side of the aisle, but I do not let any ideological blinders get in my way. If Medicare+Choice, a private program, is going to solve their problem, great, but let's provide it with the funds, particularly in more suburban, high-cost areas so it can actually work.

Here is another statistic. In addition, 52 percent of Hispanic and 40 percent of African-American Medicare beneficiaries who do not have Medicaid or group health depend on Medicare+Choice. So this is an area that affects typical Americans: hard-working retirees, who have not made a windfall, who made a decent living just by the sweat of their brow, and now they are retired and are on a fixed income, they need some kind of help that goes beyond Medicare because they have a large prescription drug bill or they need something else. Medicare+Choice becomes a health care safety net.

Again, it would be a shame if we did nothing. If we did not have this bill,

most of the Medicare+Choice Programs would have faded away or made the premiums so high they would be out of the reach of all but very comfortable people. This amendment provides the bridge between now and 2006 when we know this will work.

I know there are many Senators who are enthusiastically for this approach. I want to add that Senator KERRY, who could not be here today, wanted me to let my colleagues know how enthusiastic a supporter he is.

I hope we will work this out in the conference because it is one of the most important things that are not in this bill, once you overcome the basic disagreement we have of Medicare versus private.

AMENDMENT NO. 1040 WITHDRAWN

So I am going to withdraw the amendment because, again, we do not want to put ourselves, because of the Senate rules, under a burden of having to get much more than a majority, a 60-percent vote. We have hope because it is in the House bill. We are going to work hard in conference to see that it is kept in the conference agreement. But at this point, Madam President, I ask unanimous consent to withdraw this amendment on behalf of Senator SANTORUM, myself, and the other cosponsors.

The PRESIDING OFFICER (Mrs. DOLE). The Senator has the right to withdraw the amendment, and the amendment is withdrawn.

Mr. SCHUMER. I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. REED. Madam President, I ask unanimous consent that I be allowed to yield to the Senator from New Mexico and then retain the floor after he offers his two amendments.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from New Mexico.

Mr. BINGAMAN. Madam President, I thank my colleague from Rhode Island very much for yielding to me.

Madam President, I ask unanimous consent that the pending amendments be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1065

Mr. BINGAMAN. Madam President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN], for himself and Mr. DOMENICI, proposes an amendment numbered 1065.

Mr. BINGAMAN. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To update, beginning in 2009, the asset or resource test used for purposes of determining the eligibility of low-income beneficiaries for premium and cost-sharing subsidies)

On page 120, between lines 16 and 17, insert the following:

''(I) UPDATE OF ASSET OR RESOURCE TEST.—With respect to eligibility determinations for premium and cost-sharing subsidies under this section that are made on or after January 1, 2009, such determinations shall be made (to the extent a State, as of such date, has not already eliminated the application of an asset or resource test under section 1905(p)(1)(C)) in accordance with the following:

''(i) SELF-DECLARATION OF VALUE.—

''(I) IN GENERAL.—A State shall permit an individual applying for such subsidies to declare and certify by signature under penalty of perjury on the application form that the value of the individual's assets or resources (or the combined value of the individual's assets or resources and the assets or resources of the individual's spouse), as determined under section 1613 for purposes of the supplemental security income program, does not exceed $10,0000 ($20,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse).

''(II) ANNUAL ADJUSTMENT.—Beginning on January 1, 2010, and for each subsequent year, the dollar amounts specified in subclause (I) for the preceding year shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

''(ii) METHODOLOGY FLEXIBILITY.—Nothing in clause (i) shall be construed as prohibiting a State in making eligibility determinations for premium and cost-sharing subsidies under this section from using asset or resource methodologies that are less restrictive than the methodologies used under 1613 for purposes of the supplemental security income program.

''(J) DEVELOPMENT OF MODEL DECLARATION FORM.—The Secretary shall—

''(i) develop a model, simplified application form for individuals to use in making a self-declaration of assets or resources in accordance with subparagraph (I)(i); and

''(ii) provide such form to States and, for purposes of outreach under section 1144, the Commissioner of Social Security.''.

Mr. BINGAMAN. Madam President, just very briefly, let me state that this is the revised version of the amendment Senator DOMENICI and I had 2 days ago that would have eliminated the assets test. This keeps the assets test but reforms it very substantially.

I will explain this further when we get an opportunity to actually debate the amendment.

Madam President, I ask unanimous consent that the amendment be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1066

Mr. BINGAMAN. Madam President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN] proposes an amendment numbered 1066.

The amendment is as follows:

(Purpose: To permit the establishment of 2 new medigap plans for medicare beneficiaries enrolled for prescription drug coverage under part D)

On page 137, line 6, strike ''Notwithstanding'' and insert ''Except as provided in paragraph (4) and notwithstanding''.

On page 138, line 2, strike ''or 'G' '' and insert '' 'G', or a policy described in paragraph (4)''.

On page 138, line 17, insert '', who seeks to enroll with the same issuer who was the issuer of the policy described in clause (ii) of such subparagraph in which the individual was enrolled (unless such issuer does not offer at least one of the policies described in paragraph (4)),'' after ''section 1860D–2(b)(2)''.

On page 140, between lines 13 and 14, insert the following:

''(4) NEW STANDARDS.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Prescription Drug and Medicare Improvement Act of 2003, with respect to policies issued to individuals who are enrolled in a Medicare Prescription Drug plan under part D or under a contract under section 1860D–3(e), the changes in standards shall only provide for substituting (for the benefit packages described in paragraph (2)(B)(ii) that included coverage for prescription drugs) two benefit packages that shall be consistent with the following:

''(A) FIRST NEW POLICY.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

''(i) The policy should provide coverage for benefits other than prescription drugs similar to the coverage for benefits other than prescription drugs provided under a medicare supplemental policy which had a benefit package classified as 'H' before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003.

''(ii) The policy should provide coverage for prescription drugs that—

''(I) compliments, but does not duplicate, the benefits available under part D; and

''(II) does not cover 100 percent of the deductible, copayments, coinsurance (including any cost-sharing applicable under the limitation on out-of-pocket expenditures), or any other cost-sharing applicable under part D.

''(B) SECOND NEW POLICY.—The policy described in this subparagraph has the same benefits as the policy described in subparagraph (A), except that the reference to the benefit package classified as 'H' in clause (i) of such subparagraph is deemed to be a reference to the benefit package classified as 'J'.

(b) REPORT.—The Secretary shall enter into an arrangement with the National Association of Insurance Commissioners (in this section referred to as the ''NAIC'') under which, not later than 18 months after the date of enactment of this Act, the NAIC shall submit to Congress a report on the medicare supplemental policies described in section 1882(v)(4) of the Social Security Act, as added by subsection (a), that assesses the viability of the policies described in such section and, if viable, the details of those policies.

Mr. BINGAMAN. Madam President, just to indicate what this amendment does, this is an amendment related to Medigap and directs that a Medigap plan be developed to wrap around the prescription drug benefit that is currently in the bill.

Again, I will further explain this amendment and argue for it when we get the opportunity to do so.

I did need to have both of these amendments offered so that the Congressional Budget Office would do a score for them. Again, I thank my colleague from Rhode Island for yielding to me for that purpose.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. REED. Madam President, I rise today to discuss the historic legislation that is before this Chamber. A year ago, this body undertook a similar endeavor to bring a Medicare prescription drug benefit to the 40 million aged and disabled beneficiaries who are on the program today, as well as maintain the promise for the tens of millions of future beneficiaries who will be joining the rolls in the coming decades.

Despite the fact that a majority of Senators voted in favor of a $594 billion plan for a drug program offered by Senators GRAHAM, MILLER, and KENNEDY, procedural barriers prevented us from delivering a benefit to our elderly and disabled last year.

Since that time, Congress has passed another round of tax cuts at the President's behest, and the Nation's fiscal condition continues to deteriorate at an alarming rate. Just last week, the Congressional Budget Office announced that this administration is now on pace to shatter previous Federal budget deficit records. CBO's latest fiscal year 2003 budget deficit forecast now tops $400 billion, an increase of $100 billion over the CBO's deficit forecast offered just a month ago.

The current record budget deficit was $290 billion set in 1992. In just the first 8 months of fiscal year 2003, we have already posted a deficit of $291 billion.

Congress and the administration are now turning their attention to the long-neglected problem of a prescription drug benefit for Medicare. This year, we are faced with an arbitrary cap of $400 billion under which a drug benefit must fit. This cap is the result of the administration's insistence on dealing with the drug benefit after the tax cut and not before. Madam President, $400 billion was not sufficient when we sought to enact a meaningful prescription drug benefit last year, and I believe it is even less adequate this time.

The issue of Medicare prescription drugs is extremely important to me, and even more important to the constituents I represent.

In of a State of slightly more than a million people, 14.5 percent of the population in Rhode Island is over the age of 65 years. This is a higher proportion of older persons than the national average of 12.4 percent. According to the Census Bureau estimates, the number of elderly is expected to increase to 18.8 percent of Rhode Island's population by the year 2025. Rhode Island also has one of the highest concentrations of persons age 85 and over. Consequently, seniors in my State tend to utilize higher degrees and greater levels of health care than their counterparts in other States.

My State is also unique in terms of its health insurance market. Being a small State, Rhode Island experienced a particularly tumultuous insurance cycle during the mid-1990s that resulted in basically one insurer remaining in the market. Being dominated by a single insurance company has resulted in artificially low reimbursement rates for providers in my State. In fact, I am told Medicare is often the highest payer, sometimes 30 to 40 percent higher than some of the private options.

This has created a tremendous burden on providers in my State who are struggling to keep up with the increasing cost of doing business while continuing to provide quality care to their patients.

As Senator GRASSLEY stated at the outset of this debate, his legislation contains a provision aimed at increasing the reimbursement rate for rural providers that fall below the national average. This will make certain rural patients are not denied access to doctors and quality care. However, I believe the same assurance must be given to all Medicare beneficiaries, regardless of where they live. I am constantly hearing from providers in my State who are struggling with the drastically increasing cost of doing business. I believe we must do more to recognize regional variations in the cost of providing health care services in this country to ensure all providers are equitably compensated for services under the Medicare Program and access to care for beneficiaries is assured.

I would like to take a few moments to outline the many concerns I have regarding this legislation. I commend the Senate Finance Committee and the leadership of Senator GRASSLEY and Senator BAUCUS for their efforts to move a package forward. This is a daunting challenge. They have invested their energy and their vision and their enthusiasm over many weeks. I commend them for that.

However, I believe the proposal before this body is deficient in many significant ways. Under the legislation, seniors below 100 percent of poverty and those between 100 and 135 percent of poverty would have much of their needs covered at minimal expense. This is one of the beneficial aspects of the legislation. I must commend the Senators for insisting upon this protection for low-income seniors. Seniors between 135 and 160 percent of poverty would face a variable deduction and coinsurance.

These are beneficial aspects. If we could do more along these lines to provide assurances to low-income seniors that their benefits would be taken care of, if we could close the gap in coverage and we could do many things, this legislation would be one that would be universally supported. But there are significant shortcomings as well as the beneficial aspects.

Our elderly and disabled beneficiaries need a comprehensive Medicare prescription drug benefit now, not 3 years from now. According to the Kaiser Family Foundation, a senior today pays an average of $999 in out-of-pocket drug costs. Under the Grassley-Baucus proposal, beginning in 2004, seniors would be entitled to the Bush administration's privately run discount card program. The Government-endorsed card would provide seniors with negotiated discounts on certain drugs.

Instead of taking the time and expense to implement and dismantle a temporary discount card, we should be dedicating ourselves to implementing today a meaningful comprehensive prescription drug benefit as expeditiously as possible. I recognize the proposal before us is highly complicated and relies on a private marketplace that does not even exist and will take time to put in place. Yet if the original Medicare program could be up and running within 11 months during an era when there were no computers to speak of, I see no reason why we can't phase in the basic elements of a prescription drug program starting immediately.

I greatly fear the beneficiaries of Medicare will never see this benefit take effect when 2006 rolls around. There are a number of very plausible scenarios such as increasing Federal budget deficits, competition with the never ending drumbeat for tax cuts, and the expiration of some of the 2001 and 2003 tax cuts, the lack of private companies willing to offer these new plans, technical problems, or any number of other potential stumbling blocks that could derail implementation of this benefit, leaving seniors with nothing more than the temporary discount card as a benefit. Indeed, the bill before us continues the temporary card more than 6 months after the benefit is supposed to start.

Given the fact that Medicare beneficiaries have already waited too long for Congress to enact a prescription drug benefit, we need to do all we can to deliver a Medicare prescription drug benefit as soon as possible. Yet an effort by Senator LAUTENBERG to move up the implementation date of the new Medicare Part D program to July 1, 2004 failed. I am extremely disappointed this amendment did not prevail, leaving seniors to wait even longer for us to deliver on this promise.

The current package relies entirely on the private sector to provide a Medicare prescription drug benefit to seniors. The new Medicare Part D program created by this legislation is a significant departure from the traditional Medicare Program structure. The expectation is that Medicare HMOs and PPOs will provide the complete range of health care services, including prescription drugs, under the new MedicareAdvantage option, while drug-only plans, which currently don't exist in the health insurance marketplace,

will provide drug coverage to beneficiaries who remain in the traditional fee-for-service Medicare Program.

It is important to point out that most seniors have a favorable opinion of the existing Medicare Program and are satisfied with the coverage they receive through the traditional program. According to a recent Kaiser Family Foundation Harvard School of Public Health survey, 80 percent of seniors have a favorable impression of Medicare and 62 percent felt that the program is well run.

Seventy-two percent of people age 65 and over surveyed thought seniors should be able to continue to get their health insurance coverage through Medicare over private plans and 63 percent favored drug coverage through Medicare over private plans.

The only time a beneficiary would have access to the Medicare prescription drug fallback option under the traditional program is when no other private plans are available in their service area. However, once two drug-only plans enter the market in a particular area, this fallback option automatically disappears and a senior's choice is eliminated. He or she is forced to move to a different plan. I believe seniors should have true choice when making a decision about Medicare. They should be able to choose the Medicare prescription drug plan that best suits their needs, even if it is the Government-administrated option, which has a proven record of lower costs to taxpayers.

I support providing a level playing field for all Medicare prescription plans and was a proud cosponsor of Senator STABENOW's amendment that would have guaranteed the availability of the Medicare fallback plan as the standard option for seniors. This was not an amendment to force some outmoded Government-controlled health care system. It was an amendment about choice; indeed, a choice seniors overwhelmingly favor. Apparently we rejected that choice when we rejected the Stabenow amendment.

The Federal Government already serves as a direct provider of prescription drug benefits to millions of active-duty military personnel and veterans, so we do have a compelling Government model rather than a private sector model on which to base our expansion of Medicare.

Advocates for private sponsored prescription drug coverage under Medicare contend the private sector is more efficient and generally better suited to providing a prescription drug benefit to the elderly and disabled. I have also heard arguments that private plans are more cost-effective. However, as history has shown, the Medicare program has operated with significantly lower administrative costs than their private sector counterparts—2 to 3 percent versus 8 to 10 percent. Moreover, the Federal Government already has a long track record of providing prescription drug benefits to millions of active duty personnel and their families.

The Government also has a wealth of experience as a bulk purchaser of medications for our Nation's veterans. The TRICARE program provides comprehensive health and prescription drug coverage to 8.6 million military and their dependents. Similarly, almost 5 million of our veterans have access to prescription drug coverage for free for service-connected conditions and for a nominal $7 copay for a 30-day supply of medication for nonservice-connected ailments.

Federal health care programs have a proven track record of offering comprehensive, stable, and reliable benefits in a cost-effective manner. The facts certainly do not necessarily reflect the rhetoric when it comes to private plans.

Indeed the best model for, I think, pharmaceuticals is the Veteran's Administration and TRICARE programs, all of which are run by the Federal Government.

Under the Finance bill, premiums will vary based on geographic location and the level of benefits offered by the plan. The most recent CBO estimates indicate that the average premium for the standard prescription drug plan would be $35 in 2006 and will increase to $59 by 2013. However, private plans are free to provide a different package of benefits so long as the minimum benefit is ''actuarially equivalent'' to the standard benefit package set forth by the Government. Plans would also be free to charge beneficiaries a different premium to reflect these benefit packages. For beneficiaries on fixed incomes, these unpredictable premiums will be a great burden.

Beneficiaries will also face annual unpredictable increases in their deductible. The bill sets the deductible at $275 for 2006 and will increase in subsequent years based on the average annual per capita expenditures on covered drugs. I fear that some of the cost saving measures in this bill are ''pennywise and pound foolish.'' We should be very clear that this legislation imposes a significant amount of cost-sharing on seniors, not only in terms of the $275 deductible, variable monthly premiums and 50 percent coinsurance under the prescription drug plan, but in other areas as well. Specifically, the Grassley-Baucus proposal increases the annual deductible beneficiaries currently pay under Medicare Part B to $125 in 2006 and it indexes future increases to inflation.

I am also deeply concerned with other provisions included in this legislation to offset the cost of the rural provider payments. In particular, it imposes for the first time a beneficiary coinsurance requirement of 20 percent for diagnostic lab tests to offset a portion of these rural provider payments. I have heard from literally hundreds of providers and beneficiaries from my State in opposition to this new cost burden. In essence, what this provision translates to is an $18.6 billion shift in cost onto beneficiaries over the next decade. From a regional standpoint, absolutely none of this funding will benefit providers in my State, nor will it ensure better access to care or improve quality of care to beneficiaries in my State. Yet the over 170,000 Medicare beneficiaries in Rhode Island will be forced to pay millions in additional costs. I believe it is extremely unfair and inappropriate to boost the payments of a select group of providers at the expense of beneficiaries. The purpose of the legislation is to bring new benefits—not impose new burdens—on our elderly and disabled.

The bill also reduces the reimbursement rate for certain cancer drugs administered in a physician's office. I fear that the cumulative effect of these provisions will be increasingly limited access to care for suburban and urban beneficiaries, either because they cannot afford the deductibles and coinsurance they are expected to pay, or because they are unable to find a physician who will take Medicare.

I am also skeptical of the new ''Center for Medicare Choices'' being created under this bill to administer parts C and D of Medicare. I don't understand why the new ''Medicare Advantage'' program under Part C and the prescription drug benefit program under part D are being separated from Medicare Parts A and B under the Center for Medicare and Medicaid Services.

Scarce Federal dollars that could be directed towards providing a more generous benefit to seniors are instead being used to create a new federal bureaucracy. I am also concerned that the time and effort needed to create this new agency will slow the implementation of a drug benefit plan for seniors.

When the Medicare program was originally created in 1965, it was done in response to the fact that elderly and disabled Americans were simply unable to get affordable health insurance coverage through the private market. While many aspects of our health care system have dramatically changed since then, I believe this same basic principle holds true today.

Should this legislation pass without significant changes, Medicare beneficiaries are going to be faced with a barrage of confusing and complicated options. If we expect seniors and the disabled to be informed consumers of health care, we need to be absolutely certain that we provided the resources necessary to educate them on their options. They are going to need assistance, at least initially, in sorting through all of the relevant information to determine which option is best suited for them, based on their overall health care needs. Indeed, one third of all seniors are probably better off it they do not participate in Part D, according to CBO.

While the Grassley-Baucus proposal does take some initial steps to bolster beneficiary education through the Medicare State Health Insurance Program (SHIPS) volunteers and through

local Social Security Offices, this new program, with all its options, and new features, is going to be very confusing to the public. I believe we need to do more on education and outreach to assist beneficiaries with this new program if the program is going to be successful and effective.

For example, even today, only about half the seniors who are eligible for the various low-income assistance programs (QMB, SLMB, QI-1) enroll in those programs.

I believe we can and must do more to ensure that beneficiaries, particularly those in hard-to-reach rural and inner city communities, have access to information describing these new changes, the importance of the low-income benefit, and encouraging enrollment. I hope to work with the chairman and ranking member of the Finance Committee to make sure that all Medicare beneficiaries are well informed in terms of the parameters of the temporary discount card as well as the more comprehensive benefit.

Medicare beneficiaries who are eligible for Medicaid, known as the dual eligibles, have disproportionately high medical and long-term care needs. These seniors, including most vulnerable elderly in nursing homes, are ineligible for the drug benefit in this proposal. This population represents about 11 percent of older Americans covered by Medicare. While Medicare covers acute care and major medical expenses for this group, Medicaid picks up the cost of their prescription drugs. Since many of the dual eligibles suffer from chronic illnesses and have multiple health problems, their drug costs are extremely high. With the Gassley-Baucus proposal, the Federal Government shirks its responsibility as the primary payer by failing to assist these Medicare beneficiaries with their prescription drug costs. Indeed, it prohibits these seniors from receiving the drug benefit. It is also unclear how States' efforts to help this population will work with this proposal. Currently, States struggling with tight budgets are cutting back on care for Medicaid beneficiaries, and they are cutting optional benefits. Prescription drugs are one of Medicaid's optional benefits that States could choose to cut. The Grassley-Baucus proposal does nothing to help lift the States' burden and enable them to provide needed health care to their populations.

Under the Grassley-Baucus proposal, those low-income seniors who are not eligible for coverage through Medicaid, would as I mentioned, receive substantial Federal assistance. Unfortunately, their plan relies on state asset tests, which as Senator BINGAMAN has illustrated, can be extremely confusing and onerous for beneficiaries. Moreover, it is estimated that roughly half of all beneficiaries who would be eligible for assistance under the plan would be disqualified because of the asset test. Consequently, they would be forced to pay significantly higher deductibles, premiums and coinsurance.

So the laudable attempts to cushion the blow for low-income seniors could be undercut by maintaining this asset test.

For a vulnerable senior or disabled person struggling to get by on a fixed income, their options will not be much better than what they face now. If they are unable to afford prescription medications without coverage today, they are not going to be any better off under this plan. Low-income Medicare beneficiaries are still going to be in the unenviable position to having to choose between their medications and other basic costs, such as food and transportation.

The bill provides $250 million to reimburse local governments, hospitals and other providers for emergency health services furnished to undocumented aliens, but does not offer aid to help cover uncompensated care provided to the uninsured Americans in health care facilities around the country.

Over half of the estimated unauthorized immigrants in the United States live in five states—California, Texas, New York, Illinois and Florida. However, all States in the Union face substantial costs due to uncompensated care, regardless of immigration status.

In 2001, people who were uninsured during any part of the year receive $98.9 billion in care, of which $34.5 billion was uncompensated care. Last year, my State of Rhode Island provided more than $120 million in uncompensated care, and this is expected to grow higher this year due to the weak economy.

Local governments, hospitals, and providers throughout the United States are facing rising care costs, trying to provide services to the uninsured, which includes undocumented aliens but includes many others.

With the sluggish economy and rising deficits, States cannot alone continue to shoulder the burden placed on the health care system by the uninsured. A recent Institute of Medicine report entitled ''A Shared Destiny'' documents the impact of the uninsured and uncompensated care on communities.

The consequence of uninsurance for communities can include reduced health care services, closure of local health care institutions, increases in local cost of health care and health insurance, and poorer health for residents in general.

Federal reimbursements for health services provided to the uninsured are needed by all States. It would be more equitable to States to distribute funding based on uncompensated care determined by the number of uninsured individuals in a State as a percentage of the total number of uninsured U.S. residents rather than simply immigration status. Under the current provision, over 50 percent of the funding would go to three States, and seven States, including Montana, might not receive any funding.

Distributing funding based on the number of uninsured will help all of us. I hope Senators GRASSLEY and BAUCUS will work to explore ways in which we can address this extremely pressing issue for all States.

Another aspect of the legislation is a very serious one and one which troubles me significantly. It is the projection by CBO that 37 percent of Medicare eligibles who presently receive prescription drug coverage through an employer retirement plan will lose that coverage as a direct result of this legislation. Under this bill, over 4 million people will lose their existing prescription drug coverage.

This effect is particularly troublesome because many seniors with retiree coverage currently enjoy more generous benefits than would be provided to them under this legislation. We are all aware that some employers are already eliminating coverage or trimming back on the benefits offered to retirees. However, this legislation will likely accelerate this disturbing trend because employers see no reason to pay for a benefit the Government already provides.

I am deeply disappointed that the amendment offered by Senator ROCKEFELLER, which would have permitted drug spending by employers to count toward the out-of-pocket spending requirements of the drug benefit, was not approved. I believe the Senator's amendment would have gone a long way toward eliminating a problem of employers dropping retiree health insurance coverage.

I am also particularly concerned that legislation may have negative implications for State and local government retirees and their families. States across the Nation are suffering from staggering budget shortfalls. This legislation might present an enticing opportunity for States to slash some of their costs by shifting their retiree health insurance costs on to the Federal Government by substituting what they currently offer for what is being proposed under the Grassley-Baucus plan.

I know this would have serious implications for the over 35,000 retirees and their families currently in the Rhode Island State employees pension system as well as the almost 20,000 employees who will be expecting these benefits when they retire.

Over the past several days, my colleagues and I have brought forth amendments that would have addressed the many recognized shortcomings in the pending legislation. We have repeatedly attempted to modify the bill in a way that would have provided a stable, universal, and affordable Medicare prescription drug benefit to the almost 40 million elderly and disabled beneficiaries in America.

I fear that the product taking shape in this Chamber is only going to disappoint beneficiaries by delivering a hollow benefit that will not meet their real health care needs. Even with an additional $12 billion in resources, this body is choosing to experiment with

the privatization of Medicare over providing enhanced benefits to seniors or eliminating the gap in coverage under this plan.

For these reasons, I am unable to support this legislation. I am deeply disheartened to be reaching this conclusion, but elderly and disabled Medicare beneficiaries deserve better than the proposal before this Chamber. I only wish we were seizing this historic opportunity to provide them with a benefit they need and deserve and can be sure they will get.

I thank the Chair, and I yield the floor.

The PRESIDING OFFICER. The Senator from New York.

AMENDMENT NO. 1040

Mrs. CLINTON. Madam President, I come to the floor in support of the amendment proposed and then withdrawn by my colleague, Senator SCHUMER, that would have helped Medicare+Choice programs continue to provide insurance for their beneficiaries. This is a serious problem in New York and, I have reason to believe, in many other parts of the country because, as costs have continued to rise, many health plans are being forced to drop people from their rolls. They are actually withdrawing from large regions of New York and elsewhere in the country, leaving people to scramble for alternatives. Even those who are continuing to provide coverage are raising their premiums drastically.

Like the rest of Medicare, Medicare+Choice plans are feeling the squeeze in a system caught between rapidly exploding costs and rapidly imploding finances. Here we are on the floor debating the future of Medicare and the structure of new benefits like prescription drugs, but while we debate the future of Medicare, we need to recognize that there are people right now in our States who depend on these plans today, and the plans, when they withdraw and then reenter from year to year, cause confusion and excess costs that fall directly on the backs of our seniors. So these seniors, who are already facing rising premiums, benefit cuts, and withdrawal of services, should not be forgotten in the context of the debate we are carrying on today which will actually try to encourage more seniors to move in to these kinds of private health insurance choices.

I hope that we do something not only about the future, but we start doing something about the present and take care of our seniors who were promised better benefits in these Medicare+Choice plans only to find the rug pulled out from under them, as the plans either raised premiums, sometimes 15, 20 percent, and withdrew from their region, leaving them without the coverage for which they thought they bargained.

I fear we are setting up many more of our seniors for this kind of disappointment, confusion, and disruption if we do not heed the lessons of what has already happened.

I thank the Chair for this attention, and I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Madam President, I do not think in my 19 years in the Senate we have faced a more important and decisive issue than what is before us right now. The action the Senate will take on this bill, I believe, will set us on one of two courses.

If the Senate passes S. 1, as it is now constituted, and then goes to conference with the House—and the House bill is even worse than this one—we will have set this country on a course, inexorably, I believe, toward the privatization of Medicare and the privatization of Social Security. That is why I believe this upcoming vote is such a momentous vote.

There are those who say: We can pass it—maybe it is better than nothing—and then we can come back sometime in the future and make it better and fix it. I am not certain that is a gamble I want to take with the future of Medicare and Social Security.

The proponents of this bill are claiming that it is going to provide prescription drug coverage for seniors. Obviously, that is something we all hear about when we go back to our respective States—we know it; we sense it; we feel it; we see it—that more of our elderly are cutting their pills in half. They are not taking the prescribed medicine. They wind up in the emergency room of the hospital.

Under Medicare, if one is in the hospital, they get their drugs paid for. But if they are outside and they need drugs to keep them healthy, to keep them out of the hospital, then there is no help. I hear this from our seniors all the time.

So we know the need is there and that we should address it. We have been talking about it for a number of years.

Quite frankly, I think the bill before us, S. 1, moves the focus from the elderly and their situation and their need for an affordable, reliable prescription drug benefit, to a special interest: What is best for the drug companies? What can we do to make sure that they can continue to make the high profits they are making; to continue to be able to advertise and push these drugs on people who may demand drugs for which they could use cheaper alternatives?

The focus of this bill is a special interest focus to help the drug companies.

I have gotten over 700 phone calls in my office. Only four of them were for this bill. Seven hundred phone calls from the elderly, and only four in favor of it. I cannot believe I am the only person getting these kinds of phone calls. Funny, I have not gotten one phone call from a drug company. They are very happy and very satisfied with this bill.

So why do we find ourselves in this situation? Well, it is really only a matter of priorities. This administration and Congress had no qualms about passing enormous tax cuts amounting to $93,000 a year for millionaires and above, but now we have problems coming up with adequate funds for our Nation's seniors. This bill will not provide significant relief to the millions of seniors who need it.

Let's put it in perspective. During the last 3 years, this Congress has passed, and the President has signed, $1.6 trillion in tax cuts. That is assuming we do not continue the cuts that are already scheduled to sunset. If we do not sunset these tax cuts, it is going to amount to a lot more than that.

At the same time, we are told by CBO that seniors will have about $1.8 trillion in drug costs over the next 10 years. So do we have the picture? We have just passed $1.6 trillion in tax cuts, half of which benefit the wealthiest 1 percent in our country. Keep that figure in mind, $1.6 trillion. That is with the sunset provisions. Now, if we do not sunset them, it is going to be trillions more than that.

CBO says over the next 10 years our seniors are going to need drugs costing about $1.8 trillion. We do not have the money for that. Why? Because $1.6 trillion has already gone out for the tax cuts. After breaking the bank on these tax breaks for the wealthy, we are left with table scraps for our seniors. It is all due to a bad budget that many of us did not support. I did not vote for this budget. It was a bad budget.

We are going to see more about how bad this budget is when our appropriations bills hit the floor on education, health, and job training. We are going to see how bad this budget really was then.

Some examples of how bad I believe the provisions of this bill are: A senior living on $15,000 per year—that is just right over 160 percent of the Federal poverty level—with $1,000 in annual drug costs will actually lose money if enrolled in this program. My colleagues heard me right. If a senior is making $15,000 a year, and they have $1,000 in annual drug costs, if they join this plan, they pay more in than they get out. In fact, it is estimated that at least 35 percent, more than a third of all Medicare beneficiaries, will lose money if they enroll in this plan.

A married couple with a combined income of $20,000, again just slightly over the 160 percent of poverty level, if they had individual drug costs of $1,500 each—that is $3,000 a year in drug costs—they would save less than $400, barely 12 percent of their total drug costs.

Even seniors with high drug costs will only get modest assistance. In fact, a senior under Medicare will have to have drug costs approaching $9,000 per year before this plan will even cover a half of their expenses.

When we add together what a senior has to pay in premiums, deductibles, and cost sharing, then they have this coverage gap, the donut hole, where

they do not get 50 percent coverage until they hit $9,000 in drug costs and then they get a 50/50 split—$9,000 in drug costs before they even get 50 percent.

As I said, the plan has a donut hole, a gap, the coverage of the size of Texas, maybe Alaska. What this means for seniors is that they will pay 100 percent of their drug bill even while they are continuing to pay premiums, but they will not receive any drug coverage.

Now, there is an eruption coming. When this bill passes and it gets out there and seniors finally get in this in a couple of years, there is an eruption coming because there are going to be seniors out there saying: Wait a minute, I am paying into this thing and I do not get anything back because I fall in this gap? Wait until my colleagues start hearing from their constituents on that one.

Under this gap, once a senior's total drug costs reach $4,500, they are on their own until their catastrophic kicks in at $5,800, if I am not mistaken. But they still have to continue to pay premiums. Even though they pay for everything, they still pay the premiums. They are paying something, but they are getting nothing. That leaves a senior citizen with another $1,300 in out-of-pocket drug spending each year if they hit that gap.

That is what we call the Swiss cheese model of drug coverage. It is full of holes, and woe to you if you fall in one of them.

This bill provides too little to middle-class seniors. We tried to fix the problem. Senator BOXER offered an amendment to fill in this unfair coverage gap. The Republicans said: No, we cannot afford it.

Oh, we can afford $1.6 trillion to the wealthiest in this country, but we cannot afford to close the coverage gap. Priorities, my friends, priorities. That is what this debate is about, priorities.

The second flaw in the bill is it is a bureaucratic maze. Congress is trying to cram through one of the most significant changes in social policy in decades in 2 weeks. I am beginning to think it is because the leaders of this effort do not want seniors and the rest of the people in this country to see what is in the bill until it is too late. This is a complex, daunting, bureaucratic nightmare of a bill, and it will be for seniors.

This weekend the New York Times headlined in red ''Criticism of drug benefit is simple: It's bewildering. High level of complexity causes concern.''

With both houses of Congress poised to pass a Medicare drug bill next week, lawmakers are increasingly anxious about the complexity of the legislation and its reliance on new and largely untested arrangements to deliver drug benefits to the elderly.

This complexity, they say, may be daunting and confusing to beneficiaries, and even to insurance companies, which are supposed to manage the new benefits. Many lawmakers say they have just begun to examine the bill's intricate details and the web of political compromises behind those provisions.

Senator Larry E. Craig, Republican of Idaho, lamented the bill's ''high level of complexity and prescriptiveness.'' Senator Hillary Rodham Clinton, Democrat of New York, said it would create ''a Medicare maze, a whole new bureaucracy.''

Yes, it is bewildering. It is complex. If you think reading the bill is complex, 654 pages, I bet there are not a handful in this room who know what is in the bill—maybe a few in the committee, not many more. If you think that is bewildering, wait until the seniors start getting hit with this.

There is a reason why over the last several years when we put in Medicare+Choice for Medicare 89 percent of seniors chose to stay in traditional Medicare. Why? They want a simple, straightforward, understandable, reliable, guaranteed benefit, one in which they get coverage for the drugs they need, one they can sign up for and it does not put you in and put you out and put you in and put you out, year after year, but it is there solidly and one that is affordable.

What they are going to get under this plan is a series of befuddling and bewildering steps just to obtain substandard drug coverage.

Let's take an example. A senior citizen, we will call him Bob, next year is going to receive a drug card. Well, ladi-da, he will get a drug card. He might already have three or four drug cards in his wallet. In fact, I had an individual in Iowa a few weeks ago who took out his wallet and he already had five prescription drug cards: One from AARP, one from the State, one from a drug company, and a couple more I did not recognize. He said: Not a one is worth a hoot.

Millions of drug cards are out there now from CVS, State programs, other private organizations, AARP. If discount cards provided anything, if they amounted to anything, they would not need a drug benefit under Medicare. There are millions of them out there. Seniors will tell you they are not worth the paper they are printed on.

The reality is for the next 2 years, seniors like Bob will be left with virtually nothing. He gets a card. If Bob were low income, next year he will receive a debit card worth $600. Consider this. Bob gets a debit card worth $600, but what happens when Bob is going to the drugstore and he is getting his prescription drugs. It is now July and he goes to the pharmacist for his refill and the pharmacist says, sorry, you are out of money. The $600 is used up. What does he do then? He goes back and he sees his friend Fred, and Fred says, Well, I am still going to the drugstore and I am getting mine free. Bob wonders why he does not get his. Wait until that hits next year. Wait until your constituents start calling you up because their debit card has run out of money and it is July or August or September.

Now he has the card for a couple of years. After 2 years of having the card, it expires. It is done for. Now Bob is going to be forced to wade through hundreds of pages of health plan documents to choose which plan he wants. I decided to look at some of the plans that are out there and here are three of them. Here is Care First, Blue Cross Inc. Anyone want to try wading through this? Anyone want to read that and understand what is in there? I am a lawyer, probably not very good, but I have trouble reading that.

Here is another one from the Kaiser Foundation Health Plan of the Mid-Atlantic States. Bob will have to wade through this one, too, to figure out what he wants.

Here is one from MDIPA. This is a little smaller than the others but still pretty daunting.

In a couple of years, Bob will get a couple of these and he will be told to decide which he wants. He has to read through them and figure it out. What is he going to do, hire an accountant; hire a lawyer to figure out which plan is best for him? The plans could have different benefits, different rules, different prices, and different drugs.

Once Bob makes his choice, he could find out some of the drugs he needs are not actually covered by the plan. So he either has to change drugs or what, change plans? No, Bob cannot do that. He can do that at the end of a year. But if he finds out his drugs are not covered, he cannot switch. He has to wait until the end of the year. If Bob chooses one of the new PPO plans, the preferred provider plans, he might even have to change doctors to become part of it because they will list only certain doctors.

If that is not enough, once Bob chooses a plan and he is in it, his monthly premiums may skyrocket past $35 a month at any point in time. I have said to some people, That cannot be right; surely they cannot do that. But it is in the bill. It is in the 654-page bill. If you belong to a plan, any time that plan wants to raise the premium, you have to pay it. You cannot get out of the plan. You have to stay in it. So you have signed up for a plan. It says it will charge $35 a month. After a couple of months, the plan figures out it is not making enough money and now the premiums will be $45 a month. Why, you can write your Senator and tell your Senator how unfair this is. Guess what. Your Senator cannot do a darn thing about it. Nowhere in this bill does it guarantee seniors will not have to pay different monthly premiums.

Senator DASCHLE offered an amendment to try to fix this significant problem so seniors would be guaranteed some protection from fluctuating monthly premiums but, again, the Republicans said no. So we are supposed to vote for a bill that cannot even tell seniors what they are getting and how much it is going to cost them. In fact, Senator LOTT, who was quoted in the New York Times this week, said:

You are going to make a huge change in an entitlement program and you don't even know how it would work, if it would work.

At least we have one Republican over there who recognizes this as a bureaucratic maze. At least the amendment of Senator DASCHLE would have given seniors some peace of mind that what they bargained for is what they were going to get.

So we are back to Bob. Now, Bob is in the plan. His premiums might skyrocket. He might find that the prescription drug coverage is unaffordable. Now Bob is down at the coffee shop with his friends. None of them make very much money, but their income levels vary a little bit. They are all basically the same. They are retired, they worked hard all their lives, and they are spending a little time watching their grandkids grow. None of them are wealthy. They weren't born with silver spoons in their mouths. They don't have a lot of stock. They are just getting by.

You know, you see them on Main Street all the time. You see them in our towns, all over our States—average, middle class elderly Americans—and they are down at the coffee shop. They start talking. Bob finds out that all of his friends pay different amounts for their prescription drugs. Bob's friend George is paying a $50 deductible. Bob says, ''How can this be?''

Well, George earns just a little less than Bob. He earns $14,000 a year. So he pays a $50 deductible. He pays a lower premium and 10 percent copay for most of his drugs.

Their other friend Joe makes a bit less money a year. He is getting around $12,000 or so a year. He pays no deductible, no premium, and a 5 percent copay for his drugs.

Bob is sitting there and he is astounded. He doesn't make much more than they do. He makes $15,000 a year. He is struggling to make ends meet at that, and he is still stuck paying 50 percent copays, large deductibles, and large premiums.

Think about how you are going to hear from your seniors who gather at the local McDonald's in the morning to have their coffee and they start talking about this. One gets drugs practically free. Someone making just a few hundred dollars more pays the full premium, the full deductible, 50 percent copays. Try explaining that to your elderly citizens when this hits the streets.

Seniors are going to know immediately that this is not fair. This is the first time in Medicare's history that we are means-testing the program, where seniors are treated differently under Medicare. I believe there are serious consequences to creating this welfare class in Medicare, and that is what we are doing. We are creating a welfare class under Medicare.

It will be incredibly confusing for seniors to have four tiers of differing benefits. Seniors will not know where they fall in these income classes. Think of it, there are four. You have 75 to 100 percent of the poverty level; you have another class from 100 to 135 percent of the Federal poverty level. You have another class from 135 to 160 percent of the Federal poverty level. And now you have another class above 160 percent of the poverty level. There are four different classes.

How does Bob know where he fits? He is going to have to go through some tests. He is going to have to fill out some forms and submit the forms so people know how much money he makes.

I had some of those forms here. Here they are right here. Here is a set of forms right now for the Commonwealth of Pennsylvania. It is 16 pages long. It is what a person has to fill out in the Commonwealth of Pennsylvania to show they are poor, if I can use that word, that they are low-income, that they need some assistance, some benefits. This is the kind of paperwork they fill out.

Here is all the information about you: where you live, what you do, what you have done in your lifetime. Any cash on hand? Any savings accounts? Any checking accounts? Any certificates of deposit? Any stocks or bonds? A boat? Do you have a Christmas or vacation club?

Does anyone own or is anyone buying a car, truck, or motorcycle? You have to fill it in—the year, make, and model.

Do you have a life insurance policy? Do you own a burial space or burial plot? This is what the elderly are going to have to start filling out. And guess who gets it. Where do they take this?

Let's say Bob's friend George—how much did I say George is making? He is making about $14,000 a year. He has to prove that. He has to prove it by filling this out.

Who does he give it to? The IRS? No. Does he give it to his Senator? No. How about his Congressman? No, he doesn't give it to the Congressman either. He gives it to his pharmacist and his doctor.

So, now, our pharmacists all over America are going to have to keep all this stuff on file. Now they are going to have to look through it to make sure that George didn't make a mistake somewhere in filling this out. Think what is going to happen to elderly all over America who now say: Wait a minute, I don't necessarily want my pharmacist to know all my business. The pharmacists are going to say: I don't want all this paperwork. Wait until that hits the streets. More paperwork for our pharmacists, more paperwork for our elderly. And they aren't going to know how to fill this out.

Not only that—assets. What if George, let's say, or George and Betty, husband and wife, fall just slightly below the $19,000 level in both incomes. So they go to fill out this paperwork to get a cut in their drug coverage, to get a better benefit. But then they hit that page on assets. What kind of assets do you have?

I know people are going to laugh about this, but this is true. Betty is going to have to have her wedding ring appraised by somebody. How much is it worth? How about family heirlooms? Let's say George and Betty had some furniture that their grandparents passed down. It is now an antique, worth some money. How much is it worth?

I said the other day, it seems to me this portion of the bill is going to be a boon to the pawnshop artists around America. They are all going to be called out to assess things and determine how much they are worth. Who is going to pay that bill? That is in the bill. You may think I am joking. It is in the bill, an asset test, and it includes things such as jewelry and furniture and, yes, even a burial plot. We are forcing this humiliating process on seniors, to prove they are poor, by filling out this complicated paperwork—an assets test.

Finally, after all of this trouble, if Bob and his friends' health plan does not make enough money off of them, they will just pull out of the market, leaving them right back where they started. We have seen this happen time and time again with Medicare HMOs all over the country. It could happen over and over and over again as the new private, drug-only HMOs come in and pull out.

The Federal fallback may be available one year but not the next. So seniors will be bounced from one plan to another plan, maybe back to Medicare, maybe to another plan. There is nothing to stop it. And if a plan is in there, and it is not making money, they are out of it.

So I guess I could ask, by now are you confused? Is it a little tough to follow what all is going to happen? Imagine how our seniors are going to feel. Senator CLINTON prepared this chart. I looked it over, and it really does kind of give you the complexity of this bill we are talking about. I will not go through it all except to say that seniors starting here, in private plan ''one,'' with a $40-a-month premium, $275 deductible, 47 percent coinsurance, no limitations on doctors—well, let's say you join this plan and then find out the drugs you need are not offered there. You file a grievance. It goes to a hearing to see whether the drug is covered. Then, let's say it is a private plan, and it doesn't make enough money, and they drop out. Then you fall back into the Federal fall back and you start all over.

It is a maze. That is what we are asking our seniors to get involved in. Keep in mind that over one-third of all seniors will have to navigate this maze—just to lose money. They have to go through this just to lose money. One-third will go through this maze, and they will pay more in than they get out.

I suspect very strongly that this whole thing was developed by people who want the system to fail. They want it to fail. This bill is an example of ideology over fact, placing all the

bets on private health plans to provide the drug benefit to seniors. It is especially bad for seniors in rural States where private plans have shown no interest in participating in the Medicare Program. This private-sector worship is derived from the belief that the free market will take care of everything: The free market is the answer to everything; if only it is just put on the free market.

Well, private enterprise or the free market does very well, thank you, when you are doing automobiles or airplanes or wicker baskets or widgets, clothes, glasses, watches, television sets, computers, and a host of other things. That is where the free market works. But the free market, the private sector, by its very nature, leaves those people behind who are not profitable, people such as those with disabilities, mental illnesses, and the elderly.

The free market did not break down the barriers to people with disabilities in our country. It was this Congress and a President and the Americans with Disabilities Act that said: No more; we are going to provide opportunities and openness in our country to people with disabilities. It was not the free market because people with disabilities simply are not profitable.

Why do you think we have health care coverage now under Medicare and private health care plans for physical illnesses but not for mental illnesses, for which we have been trying for a long time to get parity? People with mental illness are not profitable. And why do we have Medicare? Because a long time ago the private insurance companies found out that the elderly were not very profitable either. And I speak about this from personal knowledge.

When I was a senior in high school, in the small town of Cumming, IA, population 150, my mother had passed away some years before. We were a bunch of bachelors living in a house. My father was 74 years old. It was 1958. He worked most of his life in the coal mines, and he had then what they call miner's lung, also known as black lung. He had a couple of injuries. He was not in very good shape. He had no stocks. He had no bonds. He owned no property. He did not own anything.

His total income—total income—per year was less than $1,500 because, thank God, during World War II, he had worked for a while and got covered under Social Security. See, before that he had worked all his life, and there was no Social Security. But, fortunately, during World War II he worked a little bit, and got covered by Social Security, so he was getting about $1,200 or $1,300 a year. Actually, he got a little more than that because he had kids under the age of 18, me being one, and Social Security gave him a little extra, $35 a month.

So here was my dad. He was 74. He was in bad shape. He had no assets, no money. There was no Medicare out there, folks. There was nothing. Could my dad afford to see a doctor? No way. And my father did not see a doctor. But every year, like clockwork, in the middle of the winter, my dad would get sick. It happened every year. He would get sick. He had this bad lung problem. He would catch a cold, and he could not get over it. He would get pneumonia, and we would get a neighbor, with a car, and rush him to Des Moines to the hospital. They would put him in a tent, dry him out, get his lungs down, and cure his pneumonia. They would send him home after a couple weeks.

How did we afford to do that? We did not have anything. I will tell you how we afforded it. Thank God for the Sisters of Mercy at a Catholic hospital in Des Moines, IA, who gave us charity because he did not have anything. That is the only way that my father got health care.

Now, why didn't some insurance company rush out to cover him at a price he could afford? Keep in mind, he was making less than $1,500 a year. He was not profitable. He was 74. He had black lung disease. He had a couple of other illnesses and injuries. My father was not profitable to an insurance company.

I can remember like it was yesterday when I came home from leave from the Navy. This was later on in 1966. I came home on leave from the Navy to see my father, who was now nearing his 80th year of life. I remember when he showed me his Medicare card and said: Now I can go see a doctor. I can go to the hospital if I have to. And I don't have to take charity anymore.

I often wonder, what would my father's later years have been like, what would it have been like if he had had Medicare earlier on? How much better his life would have been, how much healthier he would have been, how much more he would have enjoyed in his elder years if he had had decent health care.

So I don't want anyone lecturing to me about how wonderful the private market is for health care for the elderly. Go tell it to somebody else, but don't tell it to me because I lived through this. That is why when someone tells me that the private sector is somehow going to take care of the elderly, I say: Wait a second, maybe the elderly who have a lot of money, but how about those at the bottom?

That is why I say what we are doing here is setting up a welfare class. Once again, people like my father will have to fill out paperwork and beg, ask to be put in a system they can afford. I guess we haven't learned anything around here. We haven't learned a thing. Maybe we have too many people here who didn't go through what I went through. I don't know. I don't know everybody's situation. I would like to think if people went through with their fathers what I went through with mine, they might have a different perspective on Medicare.

There is no reasonable rationale for relying on private health plans for prescription drugs for the elderly, even in monetary terms and costs. We know administrative costs are much lower in Medicare. We have a history. The administrative costs in Medicare are between 2 and 3 percent a year; in private health care plans, 15 percent per year administrative costs. We also know that over the last 30 years, Medicare spending has grown at a slower rate than private health care plan spending: 9.6 percent compared to 11.1 percent.

Here is a story that appeared in the Washington Post recently. It is entitled ''Bush Pushes for Expanded Private Role in Medicare.'' It reads:

> President Bush yesterday renewed his call for market competition to play a large role in Medicare's future, as the Senate wrestled over how far to go in encouraging private health plans to deliver care and prescription drug coverage to older Americans.
>
> Bush disparaged a core tradition of Medicare in which the federal government has determined what medical services are covered and how much government pays doctors and hospitals to provide them. He said Medicare would be more effective if ''health plans compete for their business and give them the coverage they need, not the coverage that a Washington bureaucrat thinks they need.

Well, with all due respect, President Bush never lived through what I lived through. His father never had to rely on charity for health care like my father did. So he can disparage Medicare because no one in his family ever gave a hoot about Medicare. They didn't need it. He has turned a cold shoulder of indifference to those who rely on Medicare.

But not only that, the President ignores history. He says the private sector can do it better. Wait a second. We have a history. We have facts. We don't have to rely upon rhetoric. We have facts. Administrative costs in Medicare, 2 to 3 percent; private health care plans, 15 percent. OK, which is more efficient? In the last 30 years, Medicare spending has grown at a slower rate than private health care plan spending has grown. So what is he talking about? What is the President talking about when he says the private health care plans can do it better?

We have a history. We have facts. We have data. That private sector, when it comes to the elderly, does not do it better.

When it comes to this private plan program, it means there is going to be less money available to actually help seniors get prescription drugs. Billions will be wasted on advertising, marketing, glossy brochures, higher payments to private plans, billions of dollars that should be going directly to seniors. And how about CEO salaries? We haven't talked about that. All these private health care plans, they pay a lot of money for their CEOs. That is fine, if they are in the private sector. But that is money that is going to be siphoned off. Last year, the drug companies in America spent more money on advertising than they did on research. Wait until this plan gets out there.

I say to every senior citizen listening to me give this talk: Get prepared. You are going to get a lot of mail in your mailbox. You are going to get a lot of brochures for this drug and that drug and this plan and that plan. You are going to get inundated with advertisements, and you are going to see them on TV. You think you see a lot now. You wait, you will see more. Why? Because now they have all this money.

I understand we are about to have an amendment that is going to provide $6 billion to the private companies to entice them into providing these plans. If they are so doggone good, why do we have to do this? ''Senate GOP Eyes Billions to Encourage Private Plans, Employers.'' I am told it is going to be $6 billion. We haven't seen it yet. Whether it is $6 billion, $5 billion, $4.5 billion, I don't know. Whatever it is, it is too much.

I mean if President Bush is right and the private sector can do it better, why do we have to bribe them? Why do we have to bribe them with taxpayers' money, $6 billion, come on and get it? Talk about hogs feeding at the trough. This is it, folks. Six billion dollars, I am told. Well, maybe $5.5 billion. I don't know what it is. But they are going to give it to entice them into this program. Why are we robbing seniors to cushion the pockets of private plans with billions of dollars of a subsidy? ''President Bush Pushes for Expanded Private Role in Medicare.''

Well, you kind of see it all coming together. The President, Republicans are pushing for all these tax breaks for their wealthy friends. And now they reward the drug companies. No cost containment at all. Let the drug companies keep boosting their prices year after year after year. And guess what. We will just keep raising the premiums on seniors. Now we get the private plans in with their expensive CEOs, their expense accounts, and we are going to bribe them with $6 billion. What a deal.

Tom Scully, the Bush administration's top Medicare official, called Medicare ''an unbelievable disaster'' and ''a dumb system'' during a recent meeting in Pennsylvania.

The third-ranking Republican in the Senate, Senator SANTORUM from Pennsylvania, said:

I believe the standard benefit, the traditional Medicare program has to be phased out.

Senator ROBERT BENNETT of Utah, on March 1:

Medicare is a disaster. Medicare will have to be overhauled. Let's create a whole new system.

Of course, we all remember the immortal words of our former House Speaker, Newt Gingrich. He didn't want to kill Medicare, he just wanted to let it ''wither on the vine.''

So let's get this straight. Seniors are telling us not to privatize Medicare; 89 percent have already voted to keep traditional Medicare. They tell us they want a less expensive, more reliable, straightforward, simple benefit, guaranteed to be there.

The facts tell us that privatizing Medicare doesn't work. We have the facts. So why did the administration, in this bill and the House bill, insist on this privatization? Because it is the first step toward total privatization of Medicare and, I believe, the first step toward privatizing Social Security.

Senator STABENOW offered an amendment I supported which would have guaranteed a Government fallback in every area of the country, so that seniors could choose traditional Medicare regardless of what private plans are offered. As we said on the Senate floor that day, this bill offers two private plans. Senator STABENOW wanted to say: OK, we will give them more choice and offer a Medicare plan. Let them all compete. The Republicans said no. They want only to have two choices for seniors between two private plans. But they don't want to let seniors be able to choose Medicare, which they have already shown.

As the Senator from Michigan stated time and time again on the Senate floor, 89 percent have already chosen Medicare. Yet somehow we are turning a deaf ear to them.

It seems to me we have a lot of talk around here about choice, but they don't want to let Medicare be one of those choices for seniors. The only choice in the bill is for HMOs and private plans. They will be the ones choosing your premiums. They will be the ones choosing your options. They will be the ones choosing your benefits. Well, you tell that to my seniors back in Iowa who have never had a private option.

The Republicans say they want to provide seniors with choice. They claim seniors should get the same type of benefits we in Congress get. Well, all right. Let me tell you what I have for drug coverage. I pay 25 percent for my drugs. That is it. I go to the drugstore and I pay 25 percent. What a nice deal; simple, straightforward. Seniors won't have coverage anywhere nearly as generous in their plan. Look at it this way. If this plan provides $400 billion over 10 years, which is what it does, CBO has estimated that senior drug costs over the same period of time will be $1.8 trillion.

Figure that out. We are providing $400 billion. The estimated drug costs are going to be $1.8 trillion, and that is probably on the lower side. That means we are leaving the seniors to cover 78 percent of the tab for drugs. I get 25 percent; seniors have to pay 78 percent. You are going to tell me that is fair? Again, there is a storm coming, when the seniors in this country find out what is in this bill and how it affects them.

So why the insistence on privatizing Medicare? Well, I think the answer is clear. Congress is choosing a special interest over seniors' interests by following ideology over facts. I said earlier today there are three reasons we are passing this bill. The first reason is because the drug companies want it. The second reason is because the drug companies want it. You guessed it, yes. The third reason is because the drug companies want it.

You might think, from my comments, that I have it in for the drug companies. Nothing could be further from the truth. I have fought for years on the floor of the Senate for more money for research—the kind of basic research that is done through the NIH, done in coordination with drug companies, taking some of that basic research and investing their own money in these drugs and bringing them to the marketplace. Some of them have been wonderful. We are making new strides in drug development every day. I have a lot of respect for our drug manufacturers who have brought a lot of these drugs to market. However, that does not mean my esteem for the drug companies would compel me to vote for a bill that will continue to allow them to make the kind of profits they make on the backs of our senior citizens who are on fixed incomes.

No, in this one case, in this area—this is where Medicare ought to provide the drug benefit. It is where Medicare—just like we do in the Veterans' Administration—ought to be the one bargaining for the prices for our elderly. Let me and the others who can afford health plans, and pay generously for them, pay the drug companies, not the elderly.

So, again, drug companies stand to gain billions of dollars from this drug benefit—trillions.

Mr. DURBIN. Will the Senator yield for a question?

Mr. HARKIN. Without losing my right to the floor, yes.

Mr. DURBIN. I, like you, have been in the House and Senate. Can you ever recall a bill involving an industry like the pharmaceutical industry, such a grand bill involving a national program, involving that industry, where that industry has been so silent during the course of the entire preparation and deliberation of the bill? I ask the Senator from Iowa, in his vast experience and with his great insight, what does he make of the silence of the pharmaceutical industry about S. 1, the pending bill?

Mr. HARKIN. Well, the Senator asks an insightful question. Earlier, I had stated—and the Senator may not have been in the Chamber—my office has received over 700 phone calls. Only four have been in favor of this bill. I have not received one phone call from a drug company.

Now, the Senator understands when we have legislation that impacts powerful industries in this country, and if it impacts them negatively, they are all out here. Our phones are ringing off the hook; lobbyists are in our offices; the private jets are parked at Dulles. They are all over the place.

So it says to me that this bill must be a great benefit to the drug companies because I haven't heard one peep

from them. I have found in my experience, I tell the Senator, in the House and in the Senate that when you see a large industry silent on a bill that impacts them so greatly, you can only come to one assumption: They must love it.

Mr. DURBIN. Will the Senator yield for a further question?

Mr. HARKIN. I will.

Mr. DURBIN. I ask the Senator, if he has had the time to read the 654 pages of S. 1, has the Senator heard from staff or anyone during the course of the days and days of debate about this S. 1, the prescription drug proposal, that it contains anything that is going to reduce the excessive increase in the cost of prescription drugs for American families and American seniors?

Mr. HARKIN. I thank the Senator again for a very insightful question. I asked my staff—and I have good staff, and they do a lot of work on health care—to look at this 654-page bill.

I said: What in there will help keep the cost of drugs down? Anything at all?

Nothing. Zero. There is nothing in the bill that is going to help keep the cost of drugs down. In fact, I say to the Senator, I think just the opposite is going to be true because this bill will allow plans to increase premiums any time they want. So you signed up for a plan, and your premium is $35 a month. The plan is not making much money. The drug company jacks up the price of the drugs a little bit. That means the plan is not making much money, but the plan can increase the premium. The drug companies are always left harmless. They can just keep jacking up the prices.

Mr. DURBIN. If the Senator, through the Chair, will yield for one more question.

(Mr. SMITH assumed the Chair.)

Mr. HARKIN. I yield for a question.

Mr. DURBIN. I am aware of Senator HARKIN's background as a Vietnam veteran and a naval aviator. The Senator is undoubtedly aware that the Veterans' Administration, which is trying its best to provide medical care for the millions of veterans in our country, has negotiated with the drug companies to bring down the cost of drugs for veterans as much as 50 percent.

Mr. HARKIN. That is right.

Mr. DURBIN. Since we have established there is no effort in this bill to bring down the cost of prescription drugs for Medicare recipients in our country, we hear from the other side of the aisle that any effort to bring down the cost of drugs is tampering with the free market.

I ask the Senator from Iowa for his objective appraisal. Does he think the Veterans' Administration is guilty of socialistic, communistic, Bolshevik behavior, tampering with the market to bring down the cost of prescription drugs for the millions of veterans who desperately need their care? I think I know the answer to the question.

Mr. HARKIN. I think the Senator knows the answer to that question. He and I have both fought hard in this Chamber for veterans benefits. I yield to no one in my support of those who have put on the uniform of this country to defend our flag, to defend our way of life, and I know the Senator from Illinois will take a back seat to no one also in that effort. We fought hard to get a veterans drug benefit that had cost containment. That is what it does.

Today, I am proud to say—I am proud—because of what we fought for here, the veterans in this country today get the cheapest prices on drugs of anyone in our country. I am proud of that fact, and they deserve it. Has it ruined the drug companies? Of course not. They are selling more drugs. Maybe they take a little bit less profit, but they are selling more drugs because now people can afford to buy them. That is what we need today. We need that kind of system Medicare could provide in dealing with the drug companies for big purchasing, bargain down the prices so the elderly can get the same price on drugs as our veterans.

I ask rhetorically a question of the Senator from Illinois.

Mr. BYRD. Will the Senator yield?

Mr. HARKIN. Does the Senator from Illinois think the drug companies are losing money on every bottle of pills a veteran buys? I can see him shaking his head. Obviously not. Veterans get their bottle of pills cheaper than anyone else. I bet my bottom dollar the drug companies are not losing a penny on any one of them. They are making money. They are just not making as much money as they are, say, if I went in and bought them.

I yield for a question without losing my right to the floor.

Mr. BYRD. Mr. President, I do not have a question except as to what the status of the legislation is at this point.

Mr. REID. Will my friend from Iowa yield so I can respond to the Senator from West Virginia?

Mr. HARKIN. I yield, without losing my right to the floor, to the assistant minority leader.

Mr. REID. I say to my friend from West Virginia, the distinguished Senator, we are trying to get some votes lined up shortly. It is my understanding Senator BYRD wishes to speak for 10 or 15 minutes on the Durbin amendment.

Mr. BYRD. I would.

Mr. REID. Senator DORGAN wishes to speak for how long on the Durbin amendment?

Mr. DORGAN. Five minutes.

Mr. REID. Does Senator STABENOW wish to speak on the Durbin amendment?

Ms. STABENOW. Five minutes.

Mr. REID. And then Senator LINDSEY GRAHAM is here to speak on what?

Mr. GRAHAM of South Carolina. To call up my amendment, 2 minutes.

Mr. REID. Of course, the Senator from Iowa has the floor. How much longer does the Senator expect to speak?

Mr. HARKIN. I do not think I will be much more than a half an hour.

Mr. REID. That kind of defeats that theory.

Mr. HARKIN. I may not be that long. I think I can wrap up in a half an hour.

Mr. REID. So much for my ideas.

Mr. HARKIN. Mr. President, as I said earlier in response to the questions asked by my friend from Illinois, it is clear S. 1, the 654 pages, is a sham, a ruse, a bewildering, complex bill that is going to cause a lot of consternation for a lot of our elderly.

Again, to the Senator from Illinois, I say, our Government, instead of using our power and influence to negotiate for better drug prices and better drug coverage on behalf of American seniors, is choosing to nurture special interest groups and big campaign donors. Why is it other industrialized nations are spending between 30 and 50 percent less on drugs than the United States? To me it is a matter of priorities.

I end my comments by saying again, before this bill came, the Republicans took care of their friends, giving the wealthiest in this country nearly $1 trillion in tax breaks. Not only did we find the money to give every millionaire $93,000 in tax cuts, we made these tax cuts retroactive to January 1 of this year.

Less than a month later, here we are, and the Republicans tell us we do not have enough money to get seniors on a fixed income real help with their prescription drug costs. Instead, next year they get a card. If you are low income, you get a $600 debit card. And then 2 years from now—actually 3 years from now in 2006—we start this class business. Some are in this class, some in another class, and some in another class. Try to figure it out.

Our job in Congress should be to use our votes to provide security for seniors, not hand out profitable favors for special interest groups.

If we are going to live up to our promise to seniors—our promise to seniors—I ask, how many Senators in this body in the last couple of years have signed pledges not to privatize Medicare, not to privatize Social Security? Our senior citizens, I know in my State and I am sure around the country, have asked us to sign those pledges. I wonder how many here have signed them not to privatize Medicare and not to privatize Social Security.

If we are going to live up to those promises we made and those documents we signed and put their interests ahead of the special interests, the only vote on this bill is a resounding no, unless this Senate, in its wisdom, adopts the amendment offered by the Senator from Illinois, Mr. DURBIN, because the Durbin amendment will work.

The Senator from Illinois has developed a comprehensive and thoughtful alternative that truly gives what our seniors want and need: comprehensive coverage with the option of staying in Medicare.

Let's take a look at the key differences between S. 1 and the Durbin amendment.

Under S. 1, seniors have to pay a $275 deductible every year. Under the Durbin amendment, there is no deductible. Under S. 1, the bill before us, seniors pay a premium not set by law but set by insurance companies, which can be raised at any time. Under the Durbin amendment, seniors will know what premium they will pay because it will be set by law. Under the bill before us, even after the deductible, seniors will still have to pay 50 percent of their drug costs, the result of which means more than one-third of seniors will actually lose money if they participate.

I have a chart that illustrates the so-called savings for seniors under the proposed drug benefit. Let's say you are a senior citizen and you are making over $14,369 a year—let's say you make $15,000 a year. Your total drug costs are $500. Your monthly drug costs about $42. Your share is $389.50. Your premium is $420. Your total out-of-pocket expenses for that year are $809.50. That means you lose $310 on your drugs. You pay in but you lose.

Let's say your total costs are $1,000 a year. Your out-of-pocket expenses are $1,057.52. You lose $58. It is not until you reach just about $1,200 a year in drug costs that you break even. If your drug costs are less than that, you lose. Try telling that to senior citizens in your State.

Let's face it, if you have an income of $15,000 a year and you live up in some of our northern States and you have a high heating bill in the wintertime, maybe you have other extraneous expenses, maybe you have to rent a place, you are not a homeowner and you have to pay rent, you have to eat, you have to buy clothes, and you are paying $500 a year in drug costs, and yet you are going to lose money? Wait until that hits the streets.

Under the Durbin amendment, seniors will pay only 30 percent of their drug costs, getting much closer to what I pay now—25 percent to 30 percent. That is it. They will know in advance they are only going to pay 30 percent.

Under the bill before us, seniors will actually lose coverage for a period of time, even while they continue to pay their premium. That is that donut. When the drug costs reach $4,500, seniors stop getting any benefits until they reach $5,800. That is $1,300 they pay out of pocket, but they continue to pay their premiums.

Under the Durbin amendment, there is no donut hole, no coverage gap.

Most importantly, the bill before us will create mass confusion for seniors who stay in traditional Medicare because for the first time they will have to negotiate private plans and deal with the possibility, if not the likelihood, that plans will come into and pull out of States year after year. The result of this volatility will be a completely unpredictable system, where seniors not only will not know what plan they will be in from year to year, but they may have to switch drugs every year as plans with different formularies come in and out of the system.

Think about the confusion that is going to cause.

The Durbin amendment opens Medicare to private competition, but it includes a real and dependable prescription drug benefit delivered by Medicare. Basically, they have stated we will let them compete with Medicare and we will provide those choices to the elderly, but the Durbin amendment is real and dependable. The Durbin amendment makes other improvements on the underlying bill, but the bottom line for seniors is simple. The Durbin amendment delivers what the bill does not, a meaningful, dependable, reliable prescription drug benefit to all seniors in all States at all times.

Now, some might say, yes, but the Durbin amendment sunsets at the end of 2009. Well, before any of my Republican colleagues start screaming bloody murder and start casting aspersions about how this may be a gimmick and a hoax, let's remember this is exactly the same thing they did, with the support of the President, to shoehorn almost a trillion dollars in tax cuts for the wealthy into a $350 billion price tag.

I always say if it is good enough for the wealthy, it ought to be good enough for our seniors, too. Let them have the same deal.

Again this is about priorities. Earlier this year the President and the Republican Congress made it clear their top priority was tax breaks to those least deserving and least in need. That is the result of their first effort. I am sure there will be more before the year is out. I already hear them over in the House talking about it. It netted each millionaire in this country a $93,000 tax cut this year.

What the Durbin amendment says to our seniors is they are also our priority. Instead of bleeding our Treasury dry by giving every tax receipt back to the richest in the Nation, the Durbin amendment says before we get too far ahead of ourselves on tax breaks for the wealthy or anything else, we are going to get seniors the help they need.

Some will come and argue his plan is too expensive, that it is not sustainable. All I can say is, this plan has roughly the same short- and long-term costs as the tax breaks we passed.

All I ask is, what are the priorities of my colleagues? As luck would have it, both the tax breaks for the wealthy and under the Durbin amendment would sunset at roughly the same time. So in the not too distant future, the new Congress and new President can again set their priorities and decide which should be continued. Should we continue the tax breaks for the wealthy or should we continue a reliable prescription drug benefit under Medicare for the elderly? That is a choice a future Congress could make.

We should not foist upon our elderly a misguided, complex, befuddling, bewildering—and these are not my words; these are words used by others—system of prescription drug coverage that will not meet their needs, that will cost them more money, that will actually cost some of them more than what they get out of it. That is what we are doing. That is what we are going to foist upon the elderly of this country, unless we adopt the Durbin amendment. If we do, then this Senator can wholeheartedly support this bill and vote for it. If not, then I will not be a part of a sham, of a ruse, to tell our elderly they are going to get something when they are not, to hold out a false hope when in fact they are not going to get the benefits they have asked us to give to them.

This Senator's priority is with the elderly. Let's deal with them first. Let's meet their needs first. Then if we have something left over, let's think about tax breaks for the wealthy. Let's not do it the other way around.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. SUNUNU. Mr. President, I ask unanimous consent the following Members be recognized to speak: Senator GRAHAM for 5 minutes, Senator BYRD for 10 minutes, Senator STABENOW for 5 minutes, Senator DOMENICI for 10 minutes, Senator DORGAN for 5 minutes, and Senator ENSIGN for 5 minutes.

Mr. REID. Mr. President, reserving the right to object, we had some votes tentatively scheduled after and that appears to have fallen by the wayside. I therefore ask that Senator BYRD be recognized for up to 15 minutes rather than 10 minutes, and Senator STABENOW for 10 minutes instead of 5 minutes, and I ask that the Senator from New Hampshire accept that modification to the unanimous consent request.

Mr. SUNUNU. Mr. President, I am happy to accommodate that request. In addition, I ask that Senator DOMENICI be recognized for 15 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from South Carolina.

AMENDMENT NO. 948, AS MODIFIED

Mr. GRAHAM of South Carolina. I ask unanimous consent the pending amendments be set aside so I can offer my amendment. I have a modified amendment at the desk that I call up, amendment No. 948.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the modified amendment.

The assistant legislative clerk read as follows:

The Senator from South Carolina [Mr. GRAHAM] proposes an amendment numbered 948, as modified.

The amendment is as follows:

(Purpose: To provide for the establishment of a National Bipartisan Commission on Medicare Reform)

At the appropriate place in title II, insert the following:

Subtitle ____—National Bipartisan Commission on Medicare Reform

SEC. ____01. MEDICAREADVANTAGE GOAL; ESTABLISHMENT OF COMMISSION.

(a) ENROLLMENT GOAL.—It is the goal of this title that, not later than January 1, 2010, at least 15 percent of individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act and enrolled under part B of such title should be enrolled in a MedicareAdvantage plan, as determined by the Center for Medicare Choices.

(b) FAILURE TO ACHIEVE GOAL.—If the goal described in subsection (a) is not met by January 1, 2012, as determined by the Center for Medicare Choices, there shall be established a commission as described in section 2.

SEC. ____02. NATIONAL BIPARTISAN COMMISSION ON MEDICARE REFORM.

(a) ESTABLISHMENT.—Upon a determination under section ____01(b) that the enrollment goal has not been met, there shall be established a commission to be known as the National Bipartisan Commission on Medicare Reform (in this section referred to as the ''Commission'').

(b) DUTIES OF THE COMMISSION.—The Commission shall—

(1) review and analyze the long-term financial condition of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

(2) identify problems that threaten the financial integrity of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under sections 1817 and 1841 of such Act (42 U.S.C. 1395i and 1395t), including—

(A) the financial impact on the medicare program of the significant increase in the number of medicare eligible individuals; and

(B) the ability of the Federal Government to sustain the program into the future;

(3) analyze potential solutions to the problems identified under paragraph (2) that will ensure both the financial integrity of the medicare program and the provision of appropriate benefits under such program, including methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals and trends in employment-related health care for retirees;

(4) make recommendations to restore the solvency of the Federal Hospital Insurance Trust Fund and the financial integrity of the Federal Supplementary Medical Insurance Trust Fund;

(5) make recommendations for establishing the appropriate financial structure of the medicare program as a whole;

(6) make recommendations for establishing the appropriate balance of benefits covered under, and beneficiary contributions to, the medicare program;

(7) make recommendations for the time periods during which the recommendations described in paragraphs (4), (5) and (6) should be implemented;

(8) make recommendations on the impact of chronic disease and disability trends on future costs and quality of services under the current benefit, financing, and delivery system structure of the medicare program;

(9) make recommendations regarding a comprehensive approach to preserve the medicare program, including ways to increase the effectiveness of the MedicareAdvantage program and to increase MedicareAdvantage enrollment rates; and

(11) review and analyze such other matters as the Commission determines appropriate.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 17 members, of whom—

(A) four shall be appointed by the President;

(B) six shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 4 shall be of the same political party;

(C) six shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 4 shall be of the same political party; and

(D) one, who shall serve as Chairperson of the Commission, shall be appointed jointly by the President, Majority Leader of the Senate, and the Speaker of the House of Representatives.

(2) DEADLINE FOR APPOINTMENT.—Members of the Commission shall be appointed by not later than October 1, 2012.

(3) TERMS OF APPOINTMENT.—The term of any member appointed under paragraph (1) shall be for the life of the Commission.

(4) MEETINGS.—The Commission shall meet at the call of the Chairperson or a majority of its members.

(5) QUORUM.—A quorum for purposes of conducting the business of the Commission shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(6) VACANCIES.—A vacancy in the membership of the Commission shall be filled, not later than 30 days after the Commission is given notice of the vacancy, in the same manner in which the original appointment was made. Such a vacancy shall not affect the power of the remaining members to carry out the duties of the Commission.

(7) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(8) EXPENSES.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(d) STAFF AND SUPPORT SERVICES.—

(1) EXECUTIVE DIRECTOR.—

(A) APPOINTMENT.—The Chairperson shall appoint an executive director of the Commission.

(B) COMPENSATION.—The executive director shall be paid the rate of basic pay for level V of the Executive Schedule under title 5, United States Code.

(2) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

(3) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(e) POWERS OF COMMISSION.—

(1) HEARINGS AND OTHER ACTIVITIES.—The Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties under this section.

(2) STUDIES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties under this section.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE AND OFFICE OF THE CHIEF ACTUARY OF THE CENTERS FOR MEDICARE & MEDICAID.—

(A) IN GENERAL.—The Director of the Congressional Budget Office or the Chief Actuary of the Center for Medicare & Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties under this section.

(B) REIMBURSEMENTS.—The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties under this section. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties under this section.

(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties under this section, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairperson of the Commission, the head of each such agency shall furnish such information to the Commission.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of Congress.

(f) REPORT.—Not later than April 1, 2014, the Commission shall submit to the President and Congress a report and an implementation bill that shall contain a detailed statement of only those recommendations, findings, and conclusions of the Commission that receive the approval of at least 11 members of the Commission.

(g) TERMINATION.—The Commission shall terminate on the date that is 30 days after the date on which the report and implementation bill is submitted under subsection (f).

SEC. ____03. CONGRESSIONAL CONSIDERATION OF REFORM PROPOSALS.

(a) DEFINITIONS.—In this section:

(1) IMPLEMENTATION BILL.—The term ''implementation bill'' means only a bill that is introduced as provided under subsection (b),

and contains the proposed legislation included in the report submitted to Congress under section ___02(f), without modification.

(2) CALENDAR DAY.—The term ''calendar day'' means a calendar day other than 1 on which either House is not in session because of an adjournment of more than 3 days to a date certain.

(b) INTRODUCTION; REFERRAL; AND REPORT OR DISCHARGE.—

(1) INTRODUCTION.—On the first calendar day on which both Houses are in session immediately following the date on which the report is submitted to Congress under section ___02(f), a single implementation bill shall be introduced (by request)—

(A) in the Senate by the Majority Leader of the Senate, for himself and the Minority Leader of the Senate, or by Members of the Senate designated by the Majority Leader and Minority Leader of the Senate; and

(B) in the House of Representatives by the Speaker of the House of Representatives, for himself and the Minority Leader of the House of Representatives, or by Members of the House of Representatives designated by the Speaker and Minority Leader of the House of Representatives.

(2) REFERRAL.—The implementation bills introduced under paragraph (1) shall be referred to any appropriate committee of jurisdiction in the Senate and any appropriate committee of jurisdiction in the House of Representatives. A committee to which an implementation bill is referred under this paragraph may report such bill to the respective House without amendment.

(3) REPORT OR DISCHARGE.—If a committee to which an implementation bill is referred has not reported such bill by the end of the 15th calendar day after the date of the introduction of such bill, such committee shall be immediately discharged from further consideration of such bill, and upon being reported or discharged from the committee, such bill shall be placed on the appropriate calendar.

(c) FLOOR CONSIDERATION.—

(1) IN GENERAL.—When the committee to which an implementation bill is referred has reported, or has been discharged under subsection (b)(3), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for any Member of the respective House to move to proceed to the consideration of the implementation bill, and all points of order against the implementation bill (and against consideration of the implementation bill) are waived. The motion is highly privileged in the House of Representatives and is privileged in the Senate. The motion is not subject to amendment, or to a motion to postpone, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the implementation bill is agreed to, the implementation bill shall remain the unfinished business of the respective House until disposed of.

(2) AMENDMENTS.—An implementation bill may not be amended in the Senate or the House of Representatives.

(3) DEBATE.—Debate on the implementation bill, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours, which shall be divided equally between those favoring and those opposing the resolution. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the implementation bill is not in order. A motion to reconsider the vote by which the implementation bill is agreed to or disagreed to is not in order.

(4) VOTE ON FINAL PASSAGE.—Immediately following the conclusion of the debate on an implementation bill, and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the appropriate House, the vote on final passage of the implementation bill shall occur.

(5) RULINGS OF THE CHAIR ON PROCEDURE.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate or the House of Representatives, as the case may be, to the procedure relating to an implementation bill shall be decided without debate.

(d) COORDINATION WITH ACTION BY OTHER HOUSE.—If, before the passage by 1 House of an implementation bill of that House, that House receives from the other House an implementation bill, then the following procedures shall apply:

(1) NONREFERRAL.—The implementation bill of the other House shall not be referred to a committee.

(2) VOTE ON BILL OF OTHER HOUSE.—With respect to an implementation bill of the House receiving the implementation bill—

(A) the procedure in that House shall be the same as if no implementation bill had been received from the other House; but

(B) the vote on final passage shall be on the implementation bill of the other House.

(e) RULES OF SENATE AND HOUSE OF REPRESENTATIVES.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of an implementation bill described in subsection (a), and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

SEC. ___04. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary to carry out this subtitle for each of fiscal years 2012 through 2013.

Mr. GRAHAM of South Carolina. Mr. President, I offer this amendment with the hope we can negotiate a resolution and have it accepted as part of the package. The chairman of the committee has been very gracious in trying to bring that result about. Briefly, this amendment costs no money. The whole idea of reform in the bill is a new alternative traditional Medicare that will be created, called Medicare Advantage, to which people will gravitate, that allows preventive medicine practices that currently do not exist, bringing modernization to Medicare, making it more user friendly and cost effective. That is the goal of the bill, by creating a new option.

Estimates range from 2 to 43 percent participation. For those looking for reform, the only vehicle for reform in this bill I can find is the idea of Medicare Advantage, and that is somewhat minimal.

This amendment addresses the problem of ''what if.'' What if in 2010, after 4 years of enactment of this bill, the traditional Medicare is the primary choice made? What if the Medicare Advantage Program does not receive 15-percent enrollment? If it has not achieved 15-percent enrollment, creating efficiency and modernization is going to be lost.

This is the last time maybe in a generation to look at traditional Medicare and not only improve it for the senior citizen but improve it for their grandchildren who are going to have to pay for it.

Traditional Medicare, as I understand this bill, is pretty much unaffected in terms of reforms. Having a prescription drug benefit can be a good idea because it emphasizes preventive medicine practices. Having prescription drugs reasonably available can keep people healthier longer and improve the quality of life and keep them out of the hospital and do a lot of good things. But Medicare is $13 trillion short of the money we need. This bill is going to be $4 trillion additional liability. This is a chance as a body to look at the structural problems that Medicare faces.

We are increasing the age limit to 67 for Social Security eligibility. It seems to me that is a good idea given the fact people are living longer. I would like to do that with Medicare. I don't think that is oppressive. I think that is fair to grandparents and grandchildren. I believe we should have a means test. If we have a prescription drug benefit, I believe you should be asked to participate based on your ability to participate because $3 out of $4 coming into Medicare Part B comes from the General Treasury. It is truly a subsidized entitlement. These are the type of reforms I would like to see happen. I don't think they are going to happen. And the Medicare Advantage Program is the only alternative that has a reform element to it.

My amendment says in 2010, after 4 years, if 15 percent of Medicare recipients are not enrolled in Medicare Advantage, if you cannot get 15 percent to pick Medicare Advantage—you get 2 years to reach 15 percent, January of 2012. If you have not achieved 15 percent by January 2012, it is a chance to have a fail-safe mechanism requiring a commission to be appointed. The President, the House, and the Senate would appoint nine members to this commission who would study and report back to Congress in a timely manner what would be needed at that point in time to save Medicare from bankruptcy to make sure it does not blow a hole in the budget and make sure it is efficiently run. This commission has 18 months to create a work product, legislation that comes back to the House and Senate, and we vote up or down on that legislation.

This amendment will force in the future reforms that may not be achieved if we do not have adequate participation in Medicare Advantage. It takes the issue away from Congress in the sense of the commission is required to look at it and bring it back to Congress

for our input and our vote. I believe we need an element like this in this entitlement bill because if we do not have a way down the road to take a second look at this program, we are all going to suffer greatly in this Nation.

It costs no money. Hopefully, it will never have to happen. If we cannot get 15 percent of Medicare recipients to enroll in Medicare Advantage, there will be no way to reform this program. I hope we can find a resolution in a bipartisan fashion and this amendment will be accepted.

I yield the floor.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. BYRD. Mr. President, before we pat ourselves on the back, pop the champagne bottles, and fan out across America to tell seniors that their prescription drug worries are now an issue of the past, let's take a closer look at the Medicare proposal before us.

The more I read through this Medicare bill, the more I become convinced that history is once more repeating itself. I can recall a painful experience during my majority leadership when an outraged citizenry, composed mostly of seniors, forced Congress to repeal the ill-fated Medicare Catastrophic Coverage Act back in 1989. The year before, Congress was engaged in a Medicare debate eerily similar to the one we are having at this time. A bipartisan compromise was reached to make the most sweeping change in Medicare's then 23 years of existence.

Congress agreed to two key changes to the Medicare program—a prescription drug benefit and a ''stop-loss'' protection from catastrophic medical bills. Facing deficits as we do today, Congress, in its infinite wisdom, decided that beneficiaries should pay for the new benefits themselves, with the wealthiest paying the most. The new law included a complicated benefit that was too difficult to explain and a lengthy delay in the benefit's taking effect. In the end, seniors saw the bill, were confused as to what they are were getting in exchange, and wanted no part of it. Hence, it was repealed in the next session. We are poised to make the same mistake again.

I foresee a great deal of confusion and dismay occurring around kitchen tables and in corporate boardrooms across America when people actually start to read beyond the newspaper headlines and see the fine print of this plan 3 years from now. Seniors may not know whether to laugh or weep. And if no one signs up for this new Medicare plan, it will fail and fail miserably.

What incentive do seniors have to sign up for a plan that is full of coverage holes, up-front costs, and confusing paperwork? What incentive do insurance companies have to enter an untried, untested, drug-only insurance market? How can an insurance company make a plan work when almost every single participating insuree makes a claim?

Many of the 335,000 Medicare beneficiaries in West Virginia are struggling just to make ends meet and pay for the prescription medicines that sustain them. In West Virginia, the average annual income of a Medicare beneficiary is a mere $10,800.

I have to wonder, what does this prescription drug proposal mean to a 75-year-old widow from West Virginia who lives off her late husband's pension of $21,000 a year, but has $5,700 per year out-of-pocket drug costs to treat her diabetes, high blood pressure, osteoporosis, and elevated cholesterol levels?

To take advantage of this new, so-called drug benefit, she would have to spend at least $420 in yearly premiums, a $275 deductible, and then she and Medicare would each pay 50 percent of her drug costs until the costs reach $4,500, after which she would pay the remainder of her $5,700 medical bill—about another $1,000 in other words. And she could very well have to spend more given that the deductible, premiums, and copay amount are not defined in this legislation. Does this sound confusing? I am confused just trying to describe it.

Ultimately, Medicare would pay about a mere $2,000 of this poor West Virginia widow's $5,700 drug costs, a benefit of only about 35 percent. What a flimsy benefit. It doesn't even come close to the approximately 70 percent prescription drug subsidy Members of Congress receive under the Federal Employees Health Benefit Program. We wouldn't dare design health benefits for ourselves in this way.

Under this legislation, seniors in similar situations in West Virginia and across the Nation would still be forced to resort to pill splitting and desperately foregoing the medicines their doctors have prescribed.

Let's slow down and take a better look at this legislation. President Bush says he wants the Senate to pass a bill before the July recess, and so we're now engaged in a headlong rush to do just that. Members have been sitting around for days just waiting for Congressional Budget Office staff, who have been working nonstop around the clock to produce, and in some cases, reproduce cost estimates that fall within the too small budget parameters that we have required for passage. This is no way to legislate on a program of such great importance to the citizens of this country. We need more time to explain this plan to our elderly citizens. Don't we need their feedback?

I doubt that our Nation's seniors will be excited about accepting a mere half-loaf benefit. Seniors will probably want no part of it. Just like they did almost 15 years ago, when I was majority leader they may revolt, and Members of Congress could be back here scratching their heads and scrambling to find a solution and save their seats.

Senator DURBIN and I and other Senators have offered a substitute Medicare amendment that actually makes sense, and I am proud to be a cosponsor of it. The Medicare benefit under the Durbin amendment has no deductible, a guaranteed $420 yearly premium, no gaps in coverage, and a catastrophic cap on drug spending at $5,000. The Durbin amendment would also allow seniors to receive their prescription drug benefit through the traditional Medicare program or through an available private plan if they desire. Seniors would receive their prescription drug benefit as soon as possible, rather than having to wait until 2006, after the next elections. Finally, the Durbin amendment would allow the Federal Government to use the leveraging power of millions of seniors to negotiate lower prices for prescription medications.

The same widow in West Virginia with $5,700 in drug costs, would only have to spend about $2,000 under the Durbin amendment plan versus the almost $4,000 she would have to pay under the Grassley-Baucus Medicare bill before us today. I think it is quite obvious which Medicare plan the elderly citizens from West Virginia would choose.

This legislation, as it stands, also does nothing to address the high cost of prescription drugs. We should do better for our seniors. And we can do better. I believe that we can improve this legislation through the adoption of the Durbin amendment. Let's not short-change our seniors. They deserve our very best efforts.

I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, I rise also to support and I am pleased to cosponsor the Durbin amendment. But first, I ask unanimous consent to set aside the pending amendment so I may offer three amendments.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENTS NOS. 1075, 1076, 1077

Ms. STABENOW. I send the amendments to the desk and ask the reading of the amendments be waived.

The PRESIDING OFFICER. Without objection, the clerk will report the amendments by number.

The assistant legislative clerk read as follows:

The Senator from Michigan [Ms. STABENOW], for herself and Mr. LEVIN, proposes en bloc amendments numbered 1075, 1076, 1077.

The amendments are as follows:

AMENDMENT NO. 1075

(Purpose: To permanently extend a moratorium on the treatment of a certain facility as an institution for mental diseases, and for other purposes)

On page 676, after line 22, add the following:

SEC. ___. EXTENSION OF MORATORIUM.

(a) IN GENERAL.—Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 and section 4758 of the Balanced Budget Act of 1997, is amended—

(1) by striking ''until December 31, 2002'', and

(2) by striking ''Kent Community Hospital Complex in Michigan or.''

(b) EFFECTIVE DATES.—

(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

(2) MODIFICATION.—The amendment made by subsection (a)(2) shall take effect on the date of enactment of this Act.

AMENDMENT NO. 1076

(Purpose: To provide for the treatment of payments to certain comprehensive cancer centers)

On page 438, between lines 10 and 11, insert the following:

SEC. ___. COMPREHENSIVE CANCER CENTERS.

(a) IN GENERAL.—Section 1886(d)(1) of the Social Security Act (42 U.S.C. 1395ww(d)(1)) is amended—

(1) in subparagraph (B)(v)—

(A) by striking ''or'' at the end of subclause (III);

(B) by striking the semicolon at the end of subclause (IV) and inserting '', or''; and

(C) by inserting after subclause (IV) the following:

''(IV) a hospital that is a nonprofit corporation, the sole member of which was recognized as a comprehensive cancer center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that specifies in its articles of incorporation that at least 50 percent of its total discharges must have a principal finding of neoplastic disease, as defined in subparagraph (E), and that is a freestanding facility licensed for less than 131 acute care beds;''; and

(2) in subparagraph (E), by striking ''(II) and (III)'' and inserting ''(II), (III), and (IV)''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning after the date of enactment of this Act.

AMENDMENT NO. 1077

(Purpose: To provide for the redistribution of unused resident positions)

On page 438, between lines 10 and 11, insert the following:

SEC. ___. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in subparagraph (F)(i), by inserting ''subject to subparagraph (I),'' after ''October 1, 1997,'';

(2) in subparagraph (H)(i), by inserting ''and subject to subparagraph (I),'' after ''subparagraphs (F) and (G),''; and

(3) by adding at the end the following new subparagraph:

''(I) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

''(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

''(I) IN GENERAL.—If a hospital's resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2003, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

''(II) REFERENCE PERIODS DEFINED.—In this clause, the term 'reference periods' means, for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2001.

''(III) REFERENCE RESIDENT LEVEL.—Subject to subclause (IV), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during any of the reference periods.

''(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2002.

''(ii) REDISTRIBUTION.—

''(I) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

''(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2003, or before the date of the hospital's application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2004.

''(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

''(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

''(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital.

''(VI) CONSTRUCTION.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

''(iii) RESIDENT LEVEL AND LIMIT DEFINED.—In this subparagraph:

''(I) RESIDENT LEVEL.—The term 'resident level' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

''(II) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) on the resident level for the hospital determined without regard to this subparagraph.''.

(b) NO APPLICATION OF INCREASE TO IME.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by adding at the end the following: ''The provisions of subsection (h)(4)(I) (determined without regard to clause (ii) thereof) shall apply with respect to the first sentence of this clause in the same manner as such provisions apply with respect to subparagraph (F) of such subsection.''.

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2004, the Secretary of Health and Human Services shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(i)(II) of the Social Security Act (as added by subsection (a)).

AMENDMENT NO. 994

Ms. STABENOW. Mr. President, I believe this is an incredibly important vote. This amendment really is about providing seniors with what they are asking. The seniors of this country, and those who are disabled, deserve our best effort. As we come together we have been spending this time putting together prescription drug coverage for seniors, debating about how to lower prices, and the Durbin amendment—which I am pleased to cosponsor—does just that. I believe the Durbin amendment is our best effort. That is what seniors are asking for.

They are not asking for more insurance forms to wade through. Most of them are not asking for more choice. They are asking for prescription drug coverage.

I was talking to someone today at lunchtime who is on Medicare. He said to me, Whatever you do, please do not do anything to Medicare. It is simple; it is easy; it is dependable; they handle my secondary insurance.

He said, I actually have a 1–800 number I call and a real person answers the phone.

He was going on and on talking about how successful and how helpful Medicare has been for him.

I said, Boy, I would love to have you come to the floor and share this with my colleagues, because we keep hearing about how awful the traditional Medicare system is.

The conversation I had with the gentleman at noon reflects what I commonly hear at home. As I said before, the seniors of this country consider Medicare—and I wish we would consider Medicare—a great American success story.

Why is the Durbin amendment the best effort we can provide? Why is it the best we can give to our seniors?

First of all, working within the dollars that have been put aside in the budget resolution, this does not require any additional funds. But, by doing this, by putting the priority on our seniors and those receiving the health care, by making that the focus, that the priority, you can create a very different benefit if your priority is to start with: What do our seniors need? What do those who are disabled need? Let's start with a system that is designed for them.

When we do that, we can create a system that does not have any deductible, no deductible at all. We can create a system that guarantees what the premium will be. Not a suggested premium like we have in the underlying bill, but we can say it is $35 a month; it is guaranteed; it is in the law. Seniors will know what to count on and what to claim for.

We can do a better job on cost savings. Instead of saying we will cover 50 percent of the cost, we can cover 70 percent. That is a big difference—70 percent of the cost.

We can make sure there is no coverage gap. In fact, no one will lose their benefits, their help with their medical payments, as they move up with greater and greater bills. The higher the bill, the more they would continue to get help.

One of the reasons this can be done is because there is a real effort to get the best possible price for our seniors. The real issue in all of this debate—and the reason we have all this convoluted, complicated process that has been going on—is the pharmaceutical industry wants to make sure all the seniors are not in one plan where they can negotiate a big group discount as with any other insurance plan. We know the veterans of this country do not pay retail because the VA gets a group discount. Well, the Durbin amendment would give our seniors that group discount. And if you do that, you can lower prices. It is still a fair return, but you can lower prices, and use those savings to provide a better benefit, to make sure there is no deductible, to make sure there is no gap in coverage for our seniors.

We also can deal with a very important issue for many of us; that is the question of employer benefits. We want to make sure our employers do not have the incentive to drop benefits. There are many people in my great State of Michigan who I have worked with in our great auto industry, and other manufacturing industries, and others that have good benefits now. We are grateful to the employers in the industries involved, and they have a history of good benefits, good wages, and good employees, I might add. We are very proud of the work that goes on in Michigan.

Now that many of our Michiganites have retired, we want to make sure we provide incentives for employers to maintain those benefits. Those lifesaving benefits are absolutely critical. And we know that in the underlying bill, unfortunately, the projection is there will be an incentive for many employers to drop or reduce benefits, which is not acceptable.

What we have in this option, in this best offer that is in front of us, is the ability to count the employer benefits toward out-of-pocket spending, which is an encouragement for employers to continue to provide the benefits they currently provide to their retirees.

Under the Durbin amendment, you would have the option of a private plan. If you would like to go into an HMO or PPO, if that is a positive experience for you, you have that choice. But it also makes sure there is a Medicare choice always, that you have an opportunity to stay within Medicare.

Then one of the most important parts of this amendment is the fact that it would take effect as soon as possible. I think one of my concerns is with all of the talk and all the news reports about a new prescription drug benefit, it is not clear to our seniors that, in fact, no help in terms of a benefit is available until 2006. There is a discount card, yes, but nothing in terms of the bill taking full effect until 2006. So this amendment would say ''as soon as possible.'' As soon as possible we want to make sure this takes effect.

The Durbin amendment puts forward our best effort. It is a better benefit. It is a defined benefit so there is dependability. It reduces prescription drug costs. It maintains choice for those who wish to have another choice other than traditional Medicare. It creates a reliable Medicare benefit fallback if you choose private insurance. If your private carrier drops you, such as happened to my mother with her Medicare+Choice plan, you would always be able to have Medicare as a permanent choice for you if that happens. We incentivize employers to maintain benefits. And, finally, the Medicare-delivered benefit can be implemented faster.

There is a lot of good work and good will among all of our colleagues to try to develop and pass a prescription drug benefit here in the Senate. I believe our seniors deserve the very best we can offer, something that is straightforward, is dependable, is reliable—a system that is based on what is best for them, not what is best for insurance companies or pharmaceutical companies or any other interest but what is best for them.

Medicare has been a great American success story. It works. It just needs to be updated. It just needs to be modernized to cover prescription drugs. I believe it also should be modernized to cover more preventive efforts and other kinds of improvements that will continue to strengthen Medicare and allow it to modernize and improve with the times.

We can do that. We can do that without going to a complicated, convoluted system that focuses more and more on efforts that ultimately could privatize Medicare.

I urge my colleagues to join in support of the Durbin amendment. Give our seniors what they are asking for.

I will share with my colleagues a chart I have used many times on this floor. Right now, 89 percent of the seniors of this country are in Medicare. They are asking—I am very confident they are asking—for the Durbin amendment. I encourage my colleagues to support it.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Nevada.

Mr. REID. Mr. President, I ask unanimous consent that if there is not a vote called following the statement by the Senator from Nevada, Mr. ENSIGN, Senator DURBIN be recognized for 15 minutes, Senator SMITH of Oregon for 5 minutes, and Senator NICKLES for 20 minutes to speak on this bill or any pending amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from New Mexico has the floor.

Mr. DOMENICI. Mr. President, I rise today to speak about this legislation. Perhaps some will not recognize my speech at all because I know there is $12 billion to be resolved, and I understand it is going to be resolved. I am speaking as if we have finished our work and we are going to vote. I am here to tell the Senate and anybody interested why I am going to vote for this legislation.

First of all, we need prescription drugs for our senior citizens.

Secondly, we have a situation, of which I am absolutely positive. From what I have heard, if I were attending the meetings in the Democratic caucus, I would hear the Democratic Senators who are informed on the subject stand up and talk about how bad this bill is. I would hear them say that it does not do enough, that it does not take care of enough poor people, that it does not have enough choice, and that all the seniors who are currently on Medicare are expected leave and go somewhere else. That is not any good.

And just as sure as that is going on, and I have inquired before making this speech if that is the case, I go to our Republican caucuses, and I hear one Senator after another speak about the shortcomings of this bill. Some speak about it with a clear-cut: ''I am not going to vote for it.'' But many speak of it in terms of: ''I just want to let you know how bad I think it is. I don't want to talk you out of it, I just want to tell you how bad it is.'' One Senator after another, then another: ''I just want to tell you how bad it is. It just won't work.''

Then somebody else on this side begins speaking about it from fiscal policy, and they say: ''It is going to cost too much. It is going to break us.'' And there are Senators in the other caucus saying: ''We are not reforming the Medicare system, and it's going to go broke. We are just adding more debt to that system.'' Now again, I have not been there, but I asked.

Then I go to our caucus, and I hear the same thing: ''The Medicare system is already somewhat bankrupt. It is not going to have sufficient money in a few years. We are going to have to start finding money for it somewhere. And this is going to add, some say, $4.5 trillion.'' That is what we have been hearing in our caucus. Some are saying: ''No, I don't want you not to vote for it, but I just want to tell you about all these problems.''

I want to tell you I am going to vote for it because I am a hope-filled Senator. I am hope filled about the future of the American economy and American prosperity. I am hope filled about American ingenuity, American breakthroughs, American science achievements, and American wellness achievements. I want to tell you about why I am hopeful.

First, we have mapped the human genome system during our lifetime. This means that we currently know where the aberrations in the human genome system are, and where all of the major diseases lie within the chromosome system of the human anatomy. That is an unheard of achievement.

Why do I speak of it while I try to talk about Medicare and prescription drugs? Because we are not living in a stagnant world. We are not living in a world that during the next 10 or 15 or 20 or 30 years that we are going to have just what we have today in terms of wellness, in terms of prescription drugs, in terms of curing illnesses. We are in the midst of the most gigantic breakthroughs in wellness. We are in the midst of breakthroughs in terms of finding cures to all kinds of human ailments and all kinds of drug breakthroughs which are going to cure people and make them well. There sits that breakthrough called the mapping of the human genome system.

At the same time we are passing this bill, science is far from stagnant. There is going on in science today something called nanoscience. Nanoscience involves the actual manipulation of atoms to create new systems and new products. While we are wondering if we are going to be able to afford this drug system we are currently putting in place, out there in all kinds of centers of higher learning, American scientists and scientists in the rest of the world are developing technology involving the manipulation of atoms to create new systems and new products.

I believe within 15 to 20 years there will be so many new products and things that will be manufactured and made that will add to the productivity of America. I mention it because it makes my vote tomorrow on this bill hope filled. I believe there are going to be productivity changes, there are going to be drug cures, there are going to be medicinal cures, there will be wellness cures. All of these things are going to happen because we are not going to be living in a stagnant system. We are going to deliver under this prescription drug bill the drugs our people need; principally with the money going to the poorest, who need the most help, and then moving it upwards so that those who are least in need will get the least help.

While we have Senators on each side finding fault with the proposal, which probably means it is pretty good, we also find them saying: ''We can't afford it.''

I am here to suggest we can afford it. As a matter of fact, I am here to say we can't afford not to do it. I am here to say with all the breakthroughs that are going to occur, we must put in place a system that is more apt to take advantage of those breakthroughs. I believe the distinguished leader of the Senate who has spoken on this subject is correct. If we have these HMOs and PPOs and these delivery systems, they are more apt to take advantage of the breakthroughs that are going to occur because of nanoscience, because of the genome, and then because there is also a huge new system called microtechnologies. Microtechnologies, believe it or not, are going to create all kinds of tiny little engines, engines that are going to be able to do all kinds of things that make products and solve problems and cure health problems.

The microtechnology system means that little tiny engines will be produced on a chip just like the chip that we now talk about. There will be engines on that chip. And, if you look at that chip with a microscope, you will actually see little engines working. Those engines may, indeed, be put in the human body to go after certain ailments and just take them on as little engines. And the illnesses will disappear or perhaps be ameliorated.

All of these things are going to happen. Nobody at the CBO, nobody at the other agencies who have evaluated whether we will be able to pay for this bill and whether we will be able to deliver on this bill, have figured in those kinds of gigantic breakthroughs that are going to occur in this American system. In fact, none of them are figuring the productivity breakthroughs that are going to occur, in this Senator's opinion, from nanoscience and microtechnology breakthroughs. Nor are they taking into consideration breakthroughs on the medicinal side that will result from our continuation of funding the NIH at about 10-percent growth a year.

I add one caveat. If I were voting on this bill and were asked, ''What should you do in addition to this bill?'' I would adopt a resolution that would require mandatory funding of the physical sciences at about 10 percent a year just like we did the NIH for the next 10 years. Then you would have the great instruments of breakthrough—the NIH, the National Institutes of Science, plus American ingenuity and business. You would have the physical sciences funded at a much higher rate than we are funding them so that nanoscience and the others I have spoken of can have their breakthrough day. So that we can, in fact, deliver what we plan to deliver under this bill.

I close where I started, by saying: For all intents and purposes, the bill is finished. It is probably not perfect, but no democracy can draw a perfect bill. It is probably better than those who are saying how bad it is, and it is probably slightly worse than those who are running around saying how great it is. But it is pretty good in terms of a delivery system that can get us started and that we can always change.

I don't fear the fact that we have a large group of Americans coming along, the generation that we are worried about, the baby boomers. I am not concerned about how we are going to pay for them and how we are going to take care of them. I believe the breakthroughs I have just discussed generally will be specific breakthroughs that will be occurring rapidly in large numbers, every year for the next 20 to 30 years. I believe that 20 years from now we will not recognize the prescription drugs being delivered today. We will not recognize what the drugs are being delivered to cure, and what they are curing because we will have made so many changes. And, almost all of these changes will be for the positive. By applying human ingenuity, human knowledge, human capacity to such basic research as the human genome or the mapping of the chromosomes and the aberrations on the chromosomes which create diseases, we are going to find cures so that we won't have to be paying the drug costs because we will have found the cures for the sicknesses.

I thought it would be a good 15 minutes, maybe 10, while we had a few lax moments, to at least let one Senator put some comments in the record that sort of set the tone for what he will be thinking about when he votes on this rather celebrated bill. I will be thinking about all the people we are going to help today, tomorrow, and next year. But I will also be thinking about all the changes that are going to occur because of these great sciences that I have just spoken of. We won't recognize what we are taking care of in 10 years. We won't recognize what medicines we are delivering. We won't recognize what diseases we are curing. And, frankly, it is entirely possible that we won't recognize the hospital system that we have delivering hospital care to our people if, in fact, the genome system really works as some people think it will.

Some are saying within 20 to 40 years we won't even have hospitals like the ones we have. There will be different kinds of institutions that will be delivering health care because of the capacity of the genome system to deliver health care in a completely different way. I hope that these words at least are helpful. They are to this Senator. They make me feel that I have something to say beyond coming down here and reading a bunch of numbers, which I used to have to do ad nauseam when I was chairman of the Budget Committee, and try to make all kinds of predictions on how you are going to have enough money for this, that, or the other thing.

To tell you the truth, this program is a close call in terms of whether we are going to be able to pay for it. It might be a close call as to whether it is the best program we can put together. But I tell you, it is the right thing to do. We don't have anything like it today, and our people, in particular poor people, suffer because of it. We ought to

fix this as soon as we can and then go to work keeping an environment in our economic system that is vibrant and healthy. We must do this so that our system can do the things that I have been discussing over the next 15 or 20 years as this prescription drug benefit delivers the prescription drugs we are talking about.

I understand my time has elapsed, and I yield the floor.

The PRESIDING OFFICER (Ms. COLLINS). Under the previous order, the Senator from North Dakota is recognized for 5 minutes.

Mr. DORGAN. Madam President, we are about to vote at some point in the coming hour or two on a series of amendments, one of which will be the Durbin amendment, called the MediSAVE amendment. I wanted to make a couple of comments about that amendment.

I regret there being a substantial difference between what is promised and what is delivered to senior citizens with respect to a prescription drug benefit in the Medicare Program. My colleague from New Mexico indicated this is not a perfect bill. It is not. It is not a terrible bill; that is certainly the case as well. It addresses an issue that almost every Senator says needs addressing, and that is adding a prescription drug benefit to the Medicare Program. But I confess, the more we have dealt with this, the clearer it is to me that we are creating the most complicated, byzantine system that we possibly could have created.

We had opportunities, and will continue to have them, to improve this bill. We have missed most of them in the last few days.

This is a horribly complicated proposal. The Durbin amendment is an amendment that provides substantially improved benefits, and I will describe all of them. These benefits are not in the underlying legislation. The average cost of prescription drugs for senior citizens in this country is about $2,300 a year.

I might say that senior citizens are about 12 percent of America's population and they consume one-third of the prescription drugs, because we know when people reach retirement age, that status of life, many of them need prescription drugs in order to deal with their health issues.

Miracle drugs provide no miracles for those who cannot afford to take them. So we understand when people reach their declining income years, we ought to put together a prescription drug plan, attach it to the Medicare Program, and give them the assurance that we did 40 years ago, that if they are sick, they can go to a hospital; they would have Medicare; and if they need prescription drugs now, give them the assurance that they will have that opportunity.

We all have talked to senior citizens, particularly women, I might say, who live on fixed incomes, alone, at an advanced age, and have a very minimal amount of income, and who tell us: I cannot afford to take the prescription drugs the doctor says I must take.

I have talked about the woman who came to me at a meeting one day and said, ''I have heart disease and diabetes.'' She must have been in her eighties. ''The doctor prescribes medicines and I have no opportunity to buy them because I cannot afford them.''

The fact is, we can do something about that. Now, my colleague, Senator DURBIN from Illinois, offers an amendment that creates a more meaningful benefit to senior citizens, No. 1. If they spend $2,300 a year, on average, for prescription drugs, the underlying bill will give them the benefit of somewhere around $600.

I will say that again. If they spend $2,300, we are going to say you have prescription drug coverage now. But the fact is, it only covers $600. My colleague's amendment will double that to $1,200.

Second, it creates a defined benefit. Under the plan before us, the Grassley-Baucus plan, there is no guaranteed benefit for seniors. The premiums are left to the insurance companies. Well, figure out what you can do, describe what the premium is going to be, and tell us later, would you?

That is no way for the Congress to define a prescription drug benefit. My colleague offers an amendment that has a defined benefit and that is exactly what our responsibility is, to define the benefit.

The other issue my colleague addresses is reduced cost. I offered an amendment that did pass that talks about the reimportation from Canada of prescription drugs, offering consumers the same drug, made by the same company, put in the same bottle, at a lower price because we pay the highest prices for prescription drugs in the world. You can buy exactly the same drug in Canada for a substantial discount.

My colleague says, with this prescription drug plan attached to the Medicare Program, what we ought to do is instruct Health and Human Services to negotiate the same group purchasing arrangements that we have done in the VA. We know how that works. We know what that saves.

There isn't any reason it should not be in this legislation. My colleague's amendment maintains a choice. People still have the opportunity to go into a private plan someplace, but they can come back to this plan, which will be a Medicare attached plan with better benefits.

So what my colleague from Illinois is offering is something that is much better, provides better benefits, provides defined benefits, provides downward pressure on prices, and it seems to me it represents what everybody in this Chamber has promised at one time or another but which none will deliver unless we start passing an amendment of this type.

We have missed a lot of good opportunities in recent days to pass amendments that would have improved this bill. I guarantee you, if we don't make some improvements, by the year 2006, when this becomes available—it should have been 2004, but the last amendment was turned down—there will be a lot of disappointed people, because they expect prescription drug coverage. Instead, they are going to get a fraction of that. We can remedy that.

The first step, it seems to me, is to vote for the Durbin amendment, the MediSAVE amendment. There are other amendments we can support as well which will make this the kind of prescription drug benefit in Medicare that senior citizens have been promised by virtually all of us.

Let's not deliver much less than we have promised. We have all promised to do something about this because we understand the need and we understand the urgency. When you reach those declining income years of life and need prescription drugs, the miracle drugs to save your life and to maintain a decent life, we understand the need to provide the help to finance those drugs. Many seniors simply cannot do it. They go to the grocery store that has a pharmacy in the back, and they have to figure out the cost of their drugs before they decide how much food they can afford. We have all heard those stories time and again.

The question is, are we going to do this? If the answer is yes, the question is, are we going to do it right? If the answer is yes, then it is voting for the Durbin amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Who is to be recognized next?

The PRESIDING OFFICER. Under the agreement, Senator ENSIGN of Nevada is to be recognized next.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Madam President, I ask that the time of the Senator from Nevada be reserved, and we now turn to Senator DURBIN who is under the consent agreement.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Illinois.

Mr. DURBIN. Madam President, I thank my colleague from Nevada. I say to my colleagues, the more they study S. 1, the more they get to know it, the more concerned they have to be. I agree with the premise that we are making a commitment for the first time to provide prescription drug help to senior citizens. This is historic. We are doing the right thing.

Then when you look at the way this has been written and try to put it in the context of your parents or grandparents making these decisions, you understand the complexity of it, the fact it does not provide the protection which a lot of people promised. Basically, when it gets down to it, this is fraught with danger and peril.

The seniors understand that. When you sit down with senior citizens and

say let me tell you what we are doing, what we are offering, the first thing they say to you is: Senator, what are you doing to keep the cost of drugs from running off the chart? I know you say you are going to help me by paying a certain percentage. What good is that percentage, Senator? My Social Security payments are going up, enough to keep up with the cost of inflation. So if you are not going to contain the cost of prescription drugs, what good is this?

That is a hard question, isn't it? But it is the right question. When you take a look at S. 1, the bill before us, the honest answer is nothing. What this bill says is we will rely on HMOs and private insurance companies to offer a prescription drug benefit.

My friend from Florida was an insurance commissioner. Senator NELSON has told us time and again what it means to deal with some of these insurance companies. As much as his expertise might bring to this debate, the greatest experts on HMOs are senior citizens. Ask them about coverage by HMOs. They despise HMOs. They know what these insurance companies are going to do.

First, they are going to nail them with a premium much more than 35 bucks a month. There is a provision in this bill which makes insurance sense but does not make common sense. It says if you have a chance to enroll in this voluntary program at the monthly premium—and let's assume for discussion it is $35—and you turn it down because it is voluntary and say you do not want to enroll in it, and then a year later or 2 years later, you think, maybe you should enroll in it, there is a provision in this bill that says your monthly premium may not be $35, it may be $100.

It makes insurance sense because it is called adverse selection. You do not want sick people to pay premiums just when they get sick. Think about that senior on a limited income who has to make a calculation as to how much they are going to pay. Look at that senior, if you are talking about a $1,000 annual prescription drug bill—I am sitting there with my mother or my grandmother, and she says to me: Son, should I pay this $35 a month? I know it is a $275 deductible.

I say: Mom, your payments are less than 100 bucks a month. You are going to end up paying more. You are not going to get any help from this plan because the first $1,000 your monthly premium is going to be added on to the help from the Government. You will be paying more than $1,000 for $1,000 worth of drugs. It may not make sense to you, mom.

OK, maybe I will not sign up.

Then a year or two later she starts getting sick and needs prescription drugs desperately, and now that monthly premium is no longer $35; it is $100. It makes insurance sense, but it does not make common sense, and that is one of the wrinkles in this bill.

When you ask the seniors about S. 1, this Grassley-Baucus bill, they are worried about this $35 premium that may be $50 or may be $100, and these are people, I hate to remind my colleagues, who are living on $400 or $500 or $600 a month.

To a Member of the Senate, $35 is not something you consider a life-threatening decision. For a senior citizen on a fixed income, a widow living alone in a small rural town in downstate Illinois or Florida, it is a big deal. Seniors have told us: I do not like this idea of $35 a month if it is not even certain that is what the premium is going to be.

Then you say to them: Incidentally, you are going to have to deal, once again, with HMOs and private insurance companies for your prescription drugs, and they start bailing out saying: What are you doing to me, Senator? I do not trust these people. That is why almost 90 percent of the people on Medicare do not sign up for the Medicare HMO. They do not trust these HMOs. They know what they are going to do.

I sat in this Chamber and heard the debates where HMOs and insurance companies make life decisions for seniors time and again, and they come down on the side of protecting their bottom line, protecting their profit, rather than protecting the health of the seniors. The seniors know this. When the Republicans come forward and say trust the HMOs, they will take care of you on prescription drugs, they will bring the prices down, you know they are not going to mistreat you, seniors are skeptical, and they have a right to be.

Let me tell you, there is an alternative which I offered. Madam President, I say to my colleagues in the Senate, I hope they will take a look at it for two reasons: No. 1, if this plan turns out to crater and bomb and the senior citizens across America say, What have you done to me; this is not what we were bargaining for, you will at least be able to say: I voted for an alternative. Sadly, it didn't make it. I hope it does, but if it does not make it, I voted for the right alternative that did not have the problems of S. 1. That is what MediSAVE offers.

For my colleagues in the Senate, unless you are sure you want to go to the bank on S. 1, that you want to walk into a senior citizens meeting and try to explain this to your constituents who live in the State of Maine or the State of Florida or the State of Pennsylvania, then for goodness' sake, think twice about a simpler, more honest, and direct approach. Let me tell you what it is.

It has a guaranteed $35-a-month premium. S. 1 guarantees nothing. No deductible and a payment by the Government of 70 percent of the drug cost; not 50 percent—70 percent. Does that sound overly generous? My colleagues in the Senate, guess what. That is what we get. That is our benefit in the Senate.

Is this lavish, luxurious, too much, over the top? I do not hear a lot of Senators complaining about it, nor Members of the House of Representatives. If it is good enough for my colleagues, is it not good enough for your mother? Is it not good enough for your grandmother? That is what it boils down to. The Durbin amendment says we are going to give seniors across this Nation the same percentage break on prescription drugs that Members of Congress get.

Yesterday, by a vote of 93 to 3, we said that is fine. We all know what that is all about. There is this little process where the bill passes the House and passes the Senate, and then there is this mystery gathering called a conference committee, the waltz kings of the House and the Senate. They waltz nonchalantly into the committee room and close the door. And out of that committee room in a day or a week or a month pops a bill twice this size that no one has read. They say: I am afraid we do not have time to read it; we have to get moving. We have to get back home. We will let our staff take a look at it.

Two weeks from now somebody will take a close look at it. They will vote and leave. How many times have we seen that happen?

After the waltz kings have gone into the conference committee and done their work, I bet you dollars to donuts MARK DAYTON'S amendment, which said Members of Congress are bound by the same prescription drug benefit as senior citizens in America, will be gone—out. We will be back at 70-percent reimbursement on our prescription drugs and say to seniors: You know, 20 percent is really all we can afford, and I hope you understand.

The alternative is 70/30. If it is good enough for Members of Congress, it is good enough for your mom and your grandmother.

There is no coverage gap under the MediSAVE amendment, and there is no coverage gap under congressional health insurance, congressional prescription drug benefits.

We have an amendment offered by Senator BOXER, and I hope my colleagues will think twice about this. To think that one could spend $4,500 in a year and then have their protection cut off for prescription drugs is something people just rationalize and say: Gosh, we wish we had more money; we would make it work. Senator BOXER brings it to the real world. What if someone you love has been diagnosed with cancer? What if they are facing some of the most expensive drug therapy—chemotherapy, radiation therapy—imaginable to save their lives and they are forking out dollar after dollar to get through this illness that could claim their life and you are praying for them every day and guess what. Come October, after they have been on this drug therapy for 9 months, this prescription drug benefit under S. 1 disappears.

What are you supposed to do? Fork it over out of pocket, if you can. Is that

an answer? MediSAVE, the alternative, says do not do that to people. Cover them completely. Make this a real insurance policy, not a game where if you are too sick we are going to nail you.

It also says let's negotiate the drug prices. That is what this is all about.

If we do not deal with the expensive drug prices in America, this is a fraud on the public. Think about it. We estimate over the next 10 years that seniors will spend $1.8 trillion on drugs. How much do we provide to help them—$400 billion. Do the math. It is less than 25 percent. But if we could bring down that cost from $1.8 trillion to a more manageable figure, that $400 billion goes further.

The Veterans' Administration has shown they can do it for our veterans. They brought down the price of prescription drugs in veterans hospitals by 50 percent. We can do the same thing for Medicare recipients if we care more about them than the profits of the drug companies. Trust me, the drug companies can bring those prices down and still continue to be the most profitable businesses in America.

These companies spend hundreds of millions of dollars a year showing people skipping through a field of wild flowers, saying, I no longer am sneezing; therefore, I need to have Claritin and Clarinex; and whatever the next generation of Claritin is going to be, please go to your doctor and beg for it.

They spend hundreds of millions of dollars on this marketing and then they say they cannot cut the cost of their drugs because it will cut into their research. Baloney. We know better. They spend more money on advertising than they do on research for new drugs, and that tells the story. They can bring down the cost of these drugs for seniors and families across America and have plenty of money left over for profit and plenty of money for research.

We say under this MediSAVE amendment this competition will reduce costs and make this drug benefit worth something to families and seniors across America.

I say to my friends, the last part of this is the most important part. Medicare will offer a drug benefit option. Those who stand back and say, Senator DURBIN, you have gone too far; Medicare is going to offer a prescription drug option; I ask them to please look back at 40 years of history and experience in America, where the Medicare Program has worked with doctors and hospitals in every city and town in America to provide the very best medical care for seniors. At the beginning of that debate, many people voted against it saying it was pure socialism, that was not the market at work, and they were right. It is not the market at work. It is the Government of this country representing the families of this country at work for them.

We believe the same should be true when it comes to prescription drugs. Medicare should offer an option. Let the Medicare administration, with no profit motive and low administrative overhead and the ability to bargain for a discounted formulary of drugs, compete with these private insurance companies, which my friends on the Republican side of the aisle insist are going to show the way in how to save money for seniors. If it is true, they will be ready to compete and the seniors can make the choice, but under this bill they cannot. There is no choice to be made.

Medicare does not offer a prescription drug option under this bill, and that tells the whole story.

The final point I will make to my colleagues is this: If they voted for Senator DAYTON's amendment yesterday, 93 to 3, saying Members of Congress are going to pay the same thing as seniors across America and my colleagues think we are going to get by with knocking that out in conference and nonchalantly passing the bill and we get 70 percent reimbursement while seniors get 20 percent reimbursement, I am sorry, the cat is out of the bag. The press corps and the American people are watching every move. Do the right thing. Bring seniors up to the level of Members of Congress. Do it now. Vote for the MediSAVE amendment and then my colleagues can go home and I think honestly say to seniors we have given them a real prescription drug benefit.

The drug companies will not like it, the HMOs will not like it, but I guarantee that parents, grandparents, and seniors across this country are going to understand they finally have a benefit that was worth the wait.

I reserve the remainder of my time.

Mr. NELSON of Florida. Will the Senator yield?

Mr. DURBIN. I yield to the Senator from Florida for a question.

The PRESIDING OFFICER. The Senator from Florida.

Mr. NELSON of Florida. I say to my colleague from Illinois, I think he has analyzed this about as well as anyone I have heard. We made promises to the senior citizens of this country that they would have a defined benefit that would cost a minimal amount with very little deductible, with no huge gap in the coverage, that would be a part of Medicare and that whatever it was to cost——

The PRESIDING OFFICER. The Senator's time has expired.

Mr. DURBIN. I ask unanimous consent for an additional 3 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. ENSIGN. Reserving the right to object, we have been waiting about an hour and a half to speak and all I can say is we have been waiting quite a long time.

Mr. DURBIN. Two additional minutes, and I will ask unanimous consent that the Senator be given 2 additional minutes for his patience.

Mr. ENSIGN. I do not need any additional time. I just wanted to speak if I could.

Mr. DURBIN. Two minutes. Does the Senator object?

Mr. ENSIGN. Okay.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. NELSON of Florida. So I compliment the Senator and ask him why, if that was the promise that was made to American seniors, are we not considering this as the major bill on the floor, the MediSAVE amendment, instead of the package we have on the floor?

Mr. DURBIN. I thank the Senator from Florida. The answer is obvious: Because the drug companies won the debate and the seniors lost it. The drug companies have no pressure whatsoever to reduce prices. Secondly, an ideology that said the private side, the insurance companies and the HMOs, are the only answer to America's future in health care overcame common sense.

Common sense has shown seniors, and the Senator knows it better than anybody in this Chamber, when the HMOs get their hands on benefits like this, seniors are going to lose out. That argument has won the day, and that is what is in S. 1.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. ENSIGN. Madam President, what is the pending business?

The PRESIDING OFFICER. The pending amendment is No. 1077, authored by the Senator from Michigan.

Mr. ENSIGN. I ask unanimous consent that the pending amendment be laid aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1024

Mr. ENSIGN. I call up amendment No. 1024.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Nevada [Mr. ENSIGN], for himself and Mrs. LINCOLN, proposes an amendment numbered 1024.

Mr. ENSIGN. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To amend title XVIII of the Social Security Act to repeal the medicare outpatient rehabilitation therapy caps)

At the appropriate place in title IV, insert the following:

SEC. ___. OUTPATIENT THERAPY CAP REPEAL.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395*l*) is amended by striking subsection (g).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2005.

Mr. ENSIGN. Madam President, there is a cap on the amount of therapy that can be given to seniors for physical therapy, occupational therapy and speech therapy, that is set to go into effect in July. There is a $1,590 cap that is set to go into effect. What we need to do is to repeal that cap and we need to do it for very good reasons.

First, the oldest and the sickest seniors will be in a situation where they have to pay 100 percent of the costs over the cap. MedPAC and independent analyses have found that one out of seven beneficiaries needing such therapies will exceed the cap. This arbitrary limitation would cause the greatest harm to the sickest and the most vulnerable of our beneficiaries. It would be those seniors who suffer from stroke, from Parkinson's disease or a similar condition that would likely exceed the therapy cap.

It would be the older, more vulnerable beneficiaries who will be most affected by this therapy cap. As beneficiaries continue to age and encounter multiple health problems, they are more likely to be the ones to exceed the cap. Unlike other requests for Medicare monies, this provision is truly a provision for the beneficiaries. It is the beneficiaries who will either bear the cost of the cap or not get care. It is a beneficiary cap on services.

In 1999, as part of the Balanced Budget Reconciliation Act, Congress passed a 2-year moratorium to prevent implementation of the caps. A year later, Congress passed an extension of that moratorium for 1 more year through 2002, and CMS has delayed implementation until July 1 of this year. So we need to act.

From a personal story, several years ago my grandmother had a total knee replacement. I visited her in the hospital when she was going through rehabilitation. Anybody who has had a total knee replacement understands it is one of the most painful surgeries you can have, as well as rehabilitation is painful. If the cap would have been in place at the time, she could have ended up being in a situation—at her income level, if she was a senior who could not afford to pay additional money—of not getting the care and rehabilitation needed for independent living. She is about 85 years old and lives on her own today because of the physical therapy.

There are many other people we will institutionalize if we do not repeal the cap. It is very important that truly needy seniors who are very sick get the rehabilitation they need for the occupational therapy, speech therapy, as well as physical therapy.

I urge our colleagues to look at this. I have talked to the chairman of the Finance Committee, and he is committed to making sure this cap does not go into effect this year. It truly would be harmful to many seniors in our population.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

AMENDMENT NO. 1073

Mr. SMITH. I ask unanimous consent to set aside the pending amendment and call up amendment No. 1073.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The bill clerk read as follows:

The Senator from Oregon [Mr. SMITH], for himself and Mr. FEINGOLD, and Ms. CANTWELL, proposes an amendment numbered 1073.

Mr. SMITH. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To allow the Secretary to include in the definition of special medicare choice plans for special needs beneficiaries plans that disproportionately serve special needs or frail, elderly beneficiaries)

On page 379, strike lines 9 through 13, and insert:

''(A) IN GENERAL.—The term 'specialized Medicare+Choice plans for special needs beneficiaries' means a Medicare+Choice plan that—

''(i) exclusively serves special needs beneficiaries (as defined in subparagraph (B)), or

''(ii) to the extent provided in regulations prescribed by the Secretary, disproportionately serves such special needs beneficiaries, frail elderly medicare beneficiaries, or both.

Mr. SMITH. I come to the floor on behalf of myself and Senator FEINGOLD and ask unanimous consent to add Senator CANTWELL as a cosponsor.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SMITH. Senator FEINGOLD and I have designed this amendment to help frail Medicare beneficiaries with special health care needs. This is truly one of those times when doing the compassionate thing is in harmony with what is cost-effective.

It is a fact that chronic illness is the highest cost, the fastest growing segment of health care. Seniors are disproportionately affected by multiple chronic conditions that require a wide array of services. More than half of all seniors have two or more chronic conditions.

Further, one in five Medicare beneficiaries has five or more chronic health conditions. These seniors account for two thirds of total Medicare expenditures.

They also see, on average, 14 different physicians annually and fill an average of 50 prescriptions per year.

These seniors require routine monitoring, treatment and coordination of care among multiple providers to prevent or delay a decline in their health.

And yet traditional Medicare does not include a care coordination benefit. However, a limited group of Medicare+Choice plans do.

''Specialized Medicare + Choice plans'' focus on frail and chronically ill Medicare beneficiaries with special needs—such as nursing home residents, nursing home certifiable beneficiaries who live in the community, and low income seniors who are eligible for both Medicare and Medicaid.

These plans provide important services absent from original Medicare such as care coordination, disease management and supportive services.

The Prescription Drug and Medicare Improvement Act of 2003 takes an important step toward providing a ''home'' for such plans to transition into mainstream Medicare by creating a designation for ''Specialized Medicare Advantage Plans for Special Needs Beneficiaries.''

The amendment I am offering today would also allow the Secretary of HHS to permit plans that disproportionately serve special needs beneficiaries to offer specialized Medicare Advantage plans.

For example, under my amendment, health plans serving a large number of seniors whose poor health places them at risk for entering nursing homes could become a specialized Medicare+Choice provider. These are known as social HMO's or SHMO's.

The Social HMO demonstration is an example of one such program that assists frail elderly with special needs but serves a mix of well and frail seniors.

One of the four Social HMO demonstrations—Kaiser's Senior Advantage II—is in my home State of Oregon.

This program is extremely popular with the seniors it serves—those with the most complex medical needs—while saving the state of Oregon millions of dollars in Medicaid costs that would have been incurred had these seniors required nursing home care.

I have several letters of support for my amendment, and I ask unanimous consent that they be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

KAISER PERMANENTE,
Portland, OR, June 24, 2003.

Hon. GORDON SMITH,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR SMITH: I am writing to thank you for your support of Kaiser Permanente's Social HMO Demonstration program through an amendment to the Medicare Prescription Drug and Reform Act of 2003. The underlying bill would establish a special designation for newly anointed ''Medicare Advantage'' plans that exclusively serve beneficiaries with special needs such as nursing home residents and dually eligible (Medicare/Medicaid) beneficiaries. Your amendment would allow the Secretary also to designate as specialized Medicare Advantage plans those that serve a disproportionate share of special needs beneficiaries.

Kaiser's ''Social HMO demonstration, Senior Advantage II, is an example of a specialized M+C plan that disproportionately serves these types of beneficiaries, including those that qualify for nursing home care but live in the community. We currently serve, 4,400 Medicare beneficiaries. Seniors with multiple chronic conditions, like many of those served by Senior Advantage II, are at greater than average risk of unnecessary hospitalizations, adverse drug interactions related to multiple drug usage, and contradictory information from different providers. Those with five or more chronic diagnosed conditions also are more than four times as likely to have functional limitations than someone with only one condition. The average Senior Advantage II members has 13 diagnoses. Like other specialty M+C plans, Kaiser has developed a wide range of chronic care and geriatric programs to efficiently respond to the health care challenges of our special needs beneficiaries. About 30% of our members are eligible for our Expanded Benefit package that allows our frailest members, those who

qualify for nursing home care, to remain independent and in the community. In fact, over three-quarters of respondents to a survey of Social HMO members indicated that the Expanded Care services were ''important or very important'' in helping them remain living at home.

Senior Advantage II has been making a difference in the lives of our most vulnerable Oregonians for two decades. The Kaiser Permanente SHMO also serves as model to integrate home and community-based care into the rest of the local organization and Kaiser nationwide. Your amendment would allow the Secretary to establish a new population-based designation for M+C plans like ours that recognizes their commitment to targeting and serving special needs beneficiaries.

Kaiser Permanente appreciates your continued support of our efforts to develop more effective programs of geriatric care and for your leadership on behalf of our nation's most vulnerable seniors.

Sincerely,

EUGENE SCANZERA,
Manager, Medicare Product Line,
Kaiser Permanente Northwest Region.

MEDICARE PAYMENT COALITION FOR FRAIL BENEFICIARIES,
Bloomington, MN, June 24, 2003.

Hon. GORDON SMITH,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR SMITH: On behalf of the Medicare Payment Coalition for Frail Beneficiaries, we offer our strong support for your amendment to the Medicare Prescription Drug and Reform Act of 2003. Your amendment would promote better care for frail elderly and seniors with complex medical conditions by establishing a special designation for certain Medicare Advantage plans serving this high-risk group.

Beneficiaries with multiple chronic conditions represent the most needy and costly group in Medicare. Those with five or more conditions see an average of 14 different physicians annually and have about 37 office visits each year. This segment of the Medicare population also is the most expensive, costing Medicare about 14 times as much as for beneficiaries who have only one chronic condition. To improve health outcomes for this vulnerable group of seniors and control Medicare costs over the long run, we need to establish a special approach for addressing the complex and ongoing nature of the problems faced by the highest-cost population.

Currently, there are only a few Medicare+Choice programs with the skill and expertise for serving special needs beneficiaries. Most of these programs operate under demonstration authority like Evercare, the Wisconsin Partnership Program, the Minnesota Senior Health Options Program and the Social HMO demonstration, although a few private plans offer plans targeted toward special needs beneficiaries. Care coordination, aggressive primary care interventions and specialized geriatric interventions used by these plans have led to improved outcomes and reduced use of expensive services such as inpatient hospital and nursing home care.

The Medicare Prescription Drug Act, as introduced, creates a designation for ''specialized Medicare Advantage plans'' for plans for exclusively serve special needs beneficiaries. Your amendment enhances this important provision by allowing the Secretary also to designate as specialized Medicare Advantages plans those that disproportionately serve special needs beneficiaries. This designation allows these plans to be recognized for intentionally targeting for service frail, chronically ill beneficiaries. This designation also could offer the Secretary greater flexibility in the administration of these plans. Historically, it has been difficult for specialized plans to transition from demonstration status to mainstream provider status because there is no mechanism for doing so. This legislation provides an important first step for this by establishing a population-based specialized plan designation and enabling an approach to managed care that simply cannot be implemented under traditional M+C arrangements.

Congress is on the verge of enacting the most profound changes to Medicare since its inception in 1965. Your amendment provides a framework for enhancing Medicare's responsive to our nation's most vulnerable and costly seniors. I extend our sincere thanks for your leadership in this important area.

Sincerely,

RICHARD J. BRINGEWATT,
Chair.

Mr. SMITH. Keeping seniors out of nursing homes by managing their health better while saving money is a win-win situation. Despite this, these specialized programs only exist in several States.

My amendment will further improve Medicare through the development of specialized programs that manage the care of Medicare's most medically complex and expensive beneficiaries more effectively, leading to improved quality of care and ultimately life for seniors with multiple conditions, while helping control Medicare costs.

It is not often that we see a proposal in the Senate that will simultaneously improve quality of health care while saving the government money, and I urge my colleagues to support this amendment. It is compassionate and it is cost effective.

AMENDMENT NO. 994

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Madam President, I rise in opposition to the Durbin amendment. I wish to make a couple of points to my colleagues about it.

No. 1, this is not a $400 billion amendment. I have been informed that the Congressional Budget Office scores this at $570 billion over 10 years. It attempts in the legislation to limit the cost by limiting the years—according to the Congressional Budget Office, effective in limiting the cost. So we are talking about $170 billion over budget allocation. That would obviously add an increasing amount of money to the unfunded liability and the Medicare Program.

One of the things we want to do, one of the reasons we were able to bring a bipartisan consensus, is to add a responsible benefit and focus the money we are going to put forward on Medicare prescription drugs to those who are the lowest income, the poorest of the poor.

We talked about that the other day; we talked about the assets test. One of the keys to this legislation is the greatest subsidies go to the lowest income.

If we take those above the Medicaid eligibility already covered by a prescription drug plan, under the plan before the Senate now the subsidy is 97.5 percent. So the Government picks up 97.5 percent of drug costs and the beneficiary 2.5 percent. That is a fairly generous subsidy for the poorest of the poor who are not otherwise covered. The very poor, Medicaid, who are already covered, are people at 75 percent of poverty up to 100 percent of poverty—obviously poor. Those who are slightly above the poverty level get a 95 percent subsidy. So for every $1 they spend 95 cents is picked up by the Federal Government. That is a very generous subsidy.

Some would argue—and I would be one—that we should have a generous subsidy. We can argue whether it is 90 or 95 or 85 or 99, but it should be a very high subsidy because these are very low income individuals who do not have assets, do not have any other way to pay for their prescriptions, and they are truly deciding whether to buy food or to take the medicine prescribed them. We do have a focus benefit on low-income.

The Senator from Illinois focuses in on those who are higher, above 160 percent of poverty, and says this program is inadequate for them. I make the argument that there are many who have said that for higher income individuals, given the fact that the vast majority of higher income individuals already have prescription drug coverage, well over 75 percent of people at 160 percent of poverty and above have existing prescription drug coverage, many provided through their employers, all of which are probably more generous than either this benefit or the one the Senator from Illinois is offering.

So what we are doing—and this is a big concern on both sides of the aisle—is our benefit plans are displacing private dollars with public dollars. The concern, at least on my part, and I think on others, is: Is that a wise thing to do? Should we be taking private plans and replacing them with public dollars? In some cases, and I would argue in most cases, under either formula—certainly under the one that is on the floor right now—probably the benefits are not as generous.

So there is an issue as to whether we should be doing this at all for higher incomes or whether we should have some sort of catastrophic benefit or some other benefit for higher income. That is what Senator ENSIGN is going to be putting forward in his plan with Senator HAGEL later on.

But I think the overwhelming sentiment among the American people is, yes, we should have a prescription drug benefit for those who have lower incomes, who can't afford it, and those who are high users of drugs because of chronic illness. But to spend a lot of additional tax dollars on higher income seniors, I think most Americans are saying that is probably not a wise expenditure of funds, to go to $570 billion or more when just a couple of years ago—less than that, I think it was a year ago—we were looking at $350 billion, or $300 billion. Now we are at $400

billion. There is no end as to how much we would like to subsidize, I am sure, from some people's perspective—everybody over the age of 65 in the Medicare Program. But I think the responsible thing to do is work within budget constraints and focus the resources on the poorest of the poor. That is what we have done.

The other criticism I have with this plan is it is a one-size-fits-all, Government-run plan. History has shown those are not necessarily the most efficient, the most cost-effective, and best-run kinds of plans.

The Senator from Illinois says we have this gap. We may have a gap, we may not, depending on how the insurer who bids on these plans structures the plan. The only thing fixed in the plan on the floor now is the deductible is $275 for those people who are at 160 percent of poverty and above; the deductible is fixed at $275.

Also fixed is the catastrophic insurance. What does that mean? That means where the Government comes in and pays 90 percent of all the costs of drug use. It comes in after the person has spent $3,700 out of pocket. So the plan does not kick in—the design between that is flexible, but the plan cannot kick in until you have spent $275, and your catastrophic benefit, that is where the Government comes in and pays 90 percent of the cost above a level of expenditures, out-of-pocket expenditures, which kicks in after you have spent $3,700. Beyond that, the plan can be structured to have all sorts of designs to provide prescription drug coverage.

The argument I would make is there are some people who would like some designs, other people would like other designs, and we should let people decide what plan fits their needs as opposed to a one-size-fits-all plan.

I see the Senator says there should be no deductible. I think most people would argue, when you have ''no deductible'' plans, you have very skewed utilization. In other words, you have people using this plan a lot more than if there were some constraint before you get your benefit. When it comes to deductibles and copayments, they are very effective in getting people to think twice as to whether they want to consume more because they have at least some stake in the consumption.

There is lots of evidence out there that suggests that people who do not pay anything for their drugs tend not to—the best way to put it—I guess—value them as much as people who do pay something. That sort of makes sense.

Mr. DURBIN. Will the Senator yield for a question?

Mr. SANTORUM. In one second. That makes sense. If you are not paying anything for something, you value it less than if you had to pay even $2 or $5 or some sort of copay.

That is important psychologically because you have better utilization, you have a better track record of people properly taking something because they have an investment, personal investment in this particular drug.

I am happy to yield for a question.

Mr. DURBIN. I ask the Senator if he would concede the point that both the underlying bill, S. 1, as well as the MediSAVE amendment require a percentage payment of prescription drug bills for every dollar spent: The underlying bill, 50 percent; the bill I proposed, 30 percent; even at catastrophic levels, 10 percent.

To say the individual is paying nothing overlooks the fact that there is a percentage requirement copay on every prescription drug for every senior under both plans.

Mr. SANTORUM. I see that you have a cost share of up to 70/30. I do not have that. I was just looking at the summary you provided, so I don't know whether there is no cost share for lower income or how the cost share works. All I know is it is up to 70/30. I do not know what that necessarily means.

I see there is no deductible, so I was commenting on those two.

If there is a cost share throughout, that is a positive thing. Maybe we would share the agreement there needs to be some sort of cost share, particularly for those who are not at poverty level. If you are at poverty level, then the cost share should be minimal because you don't want to use it as a great disincentive to the drugs prescribed to you. But if you have some income, you should have some responsibilities for putting forth some money for these drugs. That is ground we share.

As the Senator from Illinois suggests, there is cost sharing under our plan. It is a little bit more than the Senator's. But the Senator's plan is more expensive, a lot more expensive than the plan we have here.

The other problem I have is that it does not bring in any kind of private sector incentives, to try to reduce costs. One of the problems with the Medicare system today is it is a top-down, Government-run, one-size-fits-all plan, where the private sector, which administers this plan—Medicare administers it, but they do it through intermediaries which are really private sector entities.

The private sector, in a sense, administers the Medicare plan. But they are an intermediary. In other words, they are just folks who interface with the beneficiary and collect money and pay bills and do what Medicare just doesn't have the capacity to do. The problem with that is they do not have any risk in doing their job. In other words, all they do is a ministerial job. They get paid to provide a service as opposed to what we do in this plan, which is vitally important. We say to those who want to provide Medicare benefits, whether it is through the stand-alone drug benefit we are providing or through the Medicare Advantage Program, which is a PPO and HMO product which has the Medicare drug benefit integrated into the entire benefit which is inpatient and outpatient procedures, we want you to assume some of the risk.

Why is that important? What do I mean by risk? Insurance risk. The risk that if they do not manage the program well, they are going to lose money.

When that is done to insurance companies, they tend to behave differently, when they have no risk, if the plan is not run well. The risk is if they really do a bad job, they could lose the contract, and that happens on occasion. But there is no financial risk to them if they are not managing this benefit correctly.

Mr. DURBIN. Will the Senator yield for a question?

Mr. SANTORUM. Sure.

Mr. DURBIN. I thank the Senator for yielding. This is getting perilously close to a debate, which hardly ever happens on the floor of the Senate. I will gladly ask for time and yield to his questions so we can have an honest-to-goodness Senate debate. It will be a historic day.

My question is this: Is it not true that, although the Medicare agency does not provide the services but works through intermediaries, the Medicare agency attempts to control the costs by establishing what providers can be reimbursed, what hospitals and doctors can be reimbursed, as much as we are suggesting here that the drug companies would be told that they have to reduce costs for Medicare beneficiaries? Isn't that an analogy?

Mr. SANTORUM. The Senator from Illinois is correct. The way we control costs within the Medicare system is through price controls dictated by the Federal Government. There are a whole host of problems we run into all the time with the uneconomic decisions, in many cases, by CMS—which is the agency that runs Medicare—in reimbursing for services.

We have lots of places in this country where doctors will not provide services to Medicare recipients because the reimbursement does not match what their costs are. We talked to lots of hospitals and they will tell you, depending on the region—because it is different in different regions—this is a very convoluted price control system. They will tell you they are not getting the proper reimbursements for their services and they cannot afford to provide those services, or if it was not for private payers in certain regions of the country, these hospitals would be going under because of the reimbursement dictated, not by the market, not by what beneficiaries value, but by what is decided in Baltimore, MD, by a bunch of people sitting behind a desk who have no idea of what it costs in Coudersport, PA, to provide OB/GYN service, or gynecological services, in this case, because you don't have a private-sector service for Medicare recipients.

Nevertheless, the point is, you have an artificially imposed price control from a very far-removed entity. And I think at least most Members on this side of the aisle would like to see that change. We would like to see the system better reflect what the marketplace will bear as private insurance dictates. It is a much more flexible, much more dynamic system that takes into account what the beneficiary wants and what they value.

So I would argue that while I agree with the Senator from Illinois that this plan mirrors very closely the traditional Medicare plan—I do not disagree with him at all—I would argue the traditional Medicare plan is a command-and-control, top-down plan that does not work particularly well.

One of the reasons we are here today is that it takes an act of Congress to add a benefit. It should not take an act of Congress to add a benefit. We should have prescription drug coverage.

Had we had the Medicare Advantage Program in place 20 years ago, everybody in Medicare Advantage today would have a prescription drug benefit. Everybody would have it. They would have the ability to offer that benefit because they would be responding to what the consumer and the beneficiary wants. Just like today, Medicare+Choice—which is a Medicare HMO that was established 5, 6 years ago—has prescription drug benefits if you are in that program. Why? Because there are beneficiaries who want that.

Madam President, I understand the chairman of the committee would like the floor, so I will yield.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Let me say to the Senator from Pennsylvania, this is just for the purpose of a unanimous consent request. Then I will yield the floor.

Madam President, I ask unanimous consent that at 6:30 the Senate proceed to a vote in relation to Durbin amendment No. 994, to be followed by a vote in relation to the Clinton amendment No. 1000, with no second-degree amendments in order to the amendments prior to the votes, and with 2 minutes equally divided for debate prior to each vote after the first; further, that following those votes, the Senator from Iowa—me—be recognized to offer an amendment.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Reserving the right to object, in relation to the time between now and 6:30, I ask my friend from Pennsylvania, how long do you intend to speak?

Mr. SANTORUM. Madam President, I would be happy to divide the time between now and 6:30 equally between the two sides.

Mr. REID. I think that would be appropriate. I ask that the consent request of my friend from Iowa be modified to divide the time between now and 6:30 equally between the majority and minority.

The PRESIDING OFFICER. Will the Senator from Iowa accept the modification?

Mr. GRASSLEY. Yes.

Mr. REID. With the time controlled by Senator DURBIN on our side.

Mr. GRASSLEY. And the Senator from Pennsylvania on our side.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. SANTORUM. Madam President, another concern I have—and it is not a concern with the bill; it is just the marketing of the bill—is to suggest that their plan will move forward immediately. One of the comments made was that the plan before us does not take effect until 2006, and their plan will take place as soon as possible.

Let me just suggest, we went to CMS, which is the organization within the Government that runs Medicare, and other experts in the field and asked: When is the soonest possible we can have this drug benefit in place? And they said: It would not be prudent to do so before 2006, to promise before 2006, because it is rather complicated to put together.

So the reason we put in 2006 is we want a backstop. The Durbin amendment has no backstop. It just says: As soon as possible. Who knows how long that will be? We have a backstop, focusing on getting this ready for 2006, which I think is actually beneficial, and, at the same time, it does not rush the process that potentially could do something that would be imprudent and, potentially, ineffective in moving forward a plan.

So I think 2006, given all the expertise we have in this town as to what would be the proper timeframe, is the right answer. It is a good balance between making sure there is a date certain and that it is fairly quick and, at the same time, not too quick as to cause problems.

The other thing we do—and this is not mentioned in the marketing of the MediSAVE amendment—we have a plan that does go into effect immediately, unlike the Durbin amendment, which will probably be years—at least a year or 2—before it goes into effect. And there would be no coverage for anybody under that amendment.

We will have coverage immediately, starting within a few months, according to CMS, again, the agency that runs Medicare. They anticipate, with the drug card—which accomplishes much of what the Senator from Illinois has suggested they want to accomplish, which is to get a group discount or volume discount through the Federal Government—we will do that immediately, not in a year or 2 years or 3 years or however long the Durbin amendment would take, but it will do it immediately.

Within a couple of months, we will have out to every Medicare-eligible beneficiary a discount card that can replace all the other discount cards that a lot of seniors already have. It will be a single discount card that will give a discount nationally where we will be able to negotiate with a variety of different pharmaceutical companies. So it is an opportunity for us to use the volume discount to be able to reduce drug costs for seniors.

In addition to that, if you are lower income, you will receive up to $600 in money to help defray the cost of your prescriptions—not 2 years from now, not 3 years from now, but immediately—really, a few months from now, hopefully as soon as the first of the year, or maybe even sooner than the first of the year. So it really does accomplish a lot of what the Durbin amendment attempts to do.

By the way, once we move into the full-blown plan in 2006, you are going to be contracting under the stand-alone benefit which goes with the traditional fee-for-service Medicare system as well as Medicare Advantage, which is the PPO and HMO options that will be available to seniors—none of that will be available, by the way, under the Durbin amendment—but what we will do is provide the opportunity for them to negotiate these discounts with pharmaceutical companies because they will be bidding in large regions, multi-State regions, with lots of people, lots of scrips that will be filled. So they will be able to use their purchasing power to get a lot of these volume discounts.

Now, will they be as big as the Federal Government? No. But when you are looking at these kinds of volumes, there is only so much volume discount you can get. At some level you don't get any more discount. It sort of caps out. We think the prescription business will be big enough that they will get substantial discounts and accomplish exactly what the Senator from Illinois hopes to accomplish in his legislation.

It looks like the Senator from Illinois is ready to go, so I reserve the remainder of our time.

The PRESIDING OFFICER (Mr. ALEXANDER). The Senator from Illinois.

Mr. DURBIN. Mr. President, I thank the Senator from Pennsylvania.

I say to the Senator, again, I am prepared, at any point, if the Senator would like to ask a question and debate, let's try it. Let's see how the Senate works in real debate. But I really appreciate the Senator from Pennsylvania coming to the floor.

I say to the Senator, you were the first voice in opposition to this amendment. I have been coming here day after day after day. I suspected there was some opposition here—don't get me wrong—but I am glad the Senator came forward to speak his mind about this amendment.

And I congratulate you on your choice of words. Those who oppose an amendment involving Medicare use words such as ''top-down,'' ''command-and-control,'' conjuring images of commissars, Bolshevik 7-year, 10-year plans—this kind of mighty hand of government pressing down on the poor, the

poor peasant, the poor American citizen.

The sad reality is, the seniors of America don't agree with you. They like Medicare. They even like it in Pennsylvania. Do you know what we find when we say to seniors: ''We give you a choice. You don't have to stay in Medicare. You can go to a private HMO''? Eighty-nine percent of them stay in Medicare—the ''top-down, command-and-control'' system.

Now, why do they stay there?

Mr. SANTORUM. I say to the Senator from Illinois, I believe the number is 12 percent of Medicare beneficiaries participate in the Medicare+Choice Program. So it is 88 percent.

Mr. DURBIN. I am sorry I said 89. I stand corrected.

Mr. SANTORUM. If the Senator will yield further, I would also ask the Senator if he knows that Medicare+Choice is not available in most communities because they are only available in most urbanized areas.

Mr. DURBIN. I will concede the point because I can remember so well when these Medicare HMO choice plans came rolling into Illinois and so many other States and realized they couldn't make the money off seniors they planned to and pulled the rug out from under them. They called my office and they said: What happened to this Medicare HMO we were supposed to turn to? We can't trust them. They are not there. We are sticking with Medicare.

So my point to the Senator from Pennsylvania is that we are dealing here with a Medicare option which most seniors don't view as an ugly, reprehensible, big government option. They view it instead as something they are comfortable with, that America for 40 years has lived with, and has been a dramatic success since the days when President Lyndon Johnson came forward and said: There is no reason, since your mother and father, once retired, now have a little Social Security check, why they shouldn't have health care. So we are going to create Medicare. In the 1960s, we did it. It worked.

What is the proof of its value and effectiveness? The fact that seniors are living longer. It is an indication to me that this Government-run Medicare Program has worked. It pains my friends from the conservative side of the aisle to concede the fact that a Government program works, but Medicare does work. And because it has worked, seniors trust it. But my Republican friends didn't like it to start with—at least their predecessors in the Senate—and they don't care much for it today. So they are trying to find a way to move us away from this command-and-control, top-down program, and they have decided they will use prescription drugs as their stalking horse for the elimination of Medicare. That is a sad outcome.

Now they are even talking about $6 billion with which they are going to subsidize private insurance companies, a Federal subsidy to create an alternative to Medicare as part of this bill.

The goal for some—I won't ascribe this to the Senator from Pennsylvania because I don't know if this is his own philosophy—is to get rid of Medicare. They believe it is outmoded and old-fashioned. I do not. I believe Medicare offers something to seniors which the private sector cannot offer: A nonprofit, low-administrative-cost system which treats seniors the same from one edge of America to the other and basically says: We will try to keep costs under control because we speak for tens of millions of seniors.

The same approach can work effectively when it comes to prescription drugs. The MediSAVE plan, which I offer with the support of major senior citizen organizations and organized labor, says just that. If you want a private insurance company to compete, God bless you, bring them in. Give them their best opportunity. If they can beat the socks off Medicare in a region of the country, that is to the benefit of seniors. But for goodness' sake, why are those who are in favor of the private sector so afraid of Medicare as an option, the top-down, command-and-control, bureaucratic government? That happens to be what we have lived with successfully for 40 years in America under the Medicare system.

Despite all the pejorative adjectives applied, seniors don't see it that way. They trust Medicare. Some Senators may not trust it, but seniors trust it. We ought to trust them to make a choice. What is wrong with their making a choice?

Frankly, you have to be honest about this bill. There is no guarantee in here about a $35 monthly premium. Seniors could face a much larger premium, and they know it. There is no guarantee that the private HMO company offering prescription drugs is going to be around in 2 years. It could be gone. And that infuriates seniors as well. They had the rug pulled out from under them with the Medicare HMOs. They don't want the same thing happening with prescription HMOs. That is why most of them are likely to gravitate toward the Medicare style plan. That is a dagger to the heart of styptic-hearted conservatives who want to see Medicare go away. But it is a fact.

Ask your seniors in Pennsylvania, in Illinois, even in Tennessee. They will tell you they like Medicare: Please, don't give up on it. That is why I think this alternative is so important.

Frankly, what we are saying to them is, we are going to have an issue which my friend from Pennsylvania has not addressed. We are going to have an effort by Medicare and others to bring prescription drug costs down. It has worked for the Veterans' Administration, and we have 25 times as many seniors under Medicare as we have veterans.

So let us give that bargaining power to Medicare and to the private insurance companies. And who is going to win? The winners will be seniors and their families.

Mr. SANTORUM. Will the Senator from Illinois yield for a question?

Mr. DURBIN. I am happy to yield.

Mr. SANTORUM. I want to ask you, first on the Medicare+Choice plan. You say it has failed. Are you aware that the Senator from New York, Mr. SCHUMER, offered an amendment today? I encourage you to read his statement. He talked about how the Medicare+Choice plan has been dramatically underfunded. I have a letter here from July 12 of last year signed by 11 Democrats, including Senators CLINTON, SCHUMER, LIEBERMAN, CORZINE, and WYDEN, talking about how the Medicare fee-for-service plan has grown by at least 10 percent, and yet the Medicare+Choice plan has been locked in by law and growing at only 2 percent. That is the reason a lot of the Medicare+Choice plans had to leave. Are you aware of all that information?

Mr. DURBIN. I am not. I thank the Senator for bringing to it my attention. Let me make it clear: Some Medicare HMO choice plans are good. Seniors want them, and they should have the option to turn to them. In my State, though—I don't know if it happened in Pennsylvania—some of these insurance plans came in and decided they couldn't make enough money, and they cut and ran.

Mr. SANTORUM. If the Senator will continue to yield, I would suggest you look at the statement of the Senator from New York today. I ask unanimous consent that the letter to which I referred be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

UNITED STATES SENATE,
Washington, DC, July 12, 2002.

Hon. TOM DASCHLE,
Majority Leader, Hart Senate Office Building, Washington, DC.

DEAR MAJORITY LEADER DASCHLE: We are writing to express our continued support for the Medicare+Choice (M+C) program. Currently approximately 5 million Medicare beneficiaries are enrolled in M+C plans across the country and many of them live in the states we represent. For these seniors, M+C represents a vital link to high quality, affordable health coverage.

Unfortunately, a serious funding crisis is threatening the Medicare+Choice option. Many participants live in areas where funding for their M+C health benefits has increased by only two or three percent annually since 1998 while health care costs have risen by at least ten percent. These increases are inadequate and they threaten the viability of the program in most areas. We believe Congress should assign a high priority to adequately funding the Medicare+Choice program.

We understand the difficult task you face in balancing so many competing demands in the health care areas. However, we believe that M+C plays an important role in the overall soundness of the health care system, and we would like to see it continue without disruption for the seniors we represent. We hope you will consider our support for M+C as you work on Medicare legislation this year.

Sincerely,

Joseph Lieberman, Jon Corzine, Barbara Boxer, Chris Dodd, Max Cleland,

Dianne Feinstein, Ron Wydem, Charles Schumer, ———, Jean Carnahan, Hillary Rodham Clinton.

Mr. SANTORUM. Take a look at this letter. It is very clear that the reason these plans left was that we set the growth rate for Medicare HMOs at one-fifth the growth rate of the traditional Medicare Program, and obviously they couldn't continue because health care costs continued to go up. Remember, they were the only ones providing prescription drugs. So while Medicare was going up 10 percent without prescription drugs, HMOs were going up probably 10 percent or more because they were offering prescription drugs. So they said: We just can't continue, under this artificial ceiling, to continue. What we are trying to do with this plan is to put that choice back to seniors.

Mr. DURBIN. Reclaiming my time, you don't put it back in that situation. You eliminate Medicare as a competitor to these private insurance companies. The Medicare agency itself cannot offer this prescription drug plan other than through a private agency with which they contract.

What I am saying to the Senator from Pennsylvania is: Take a look at the Veterans' Administration. The Veterans' Administration is a good indication of what can happen when a Federal agency such as the Veterans' Administration wants to bring down costs; it bargains on behalf of the people it represents and lowers prescription drug costs.

Under this bill, S. 1, as I understand it, you have to have two private insurance companies offering in a region or there is a Medicare fallback, which turns out to be a plan that they contract out to some private provider.

Mr. SANTORUM. If the Senator from Illinois will yield for a question.

Mr. DURBIN. I am happy to yield.

Mr. SANTORUM. Does your plan have the benefit actually administered by the CMS or do they, like the traditional Medicare plan, contract through an intermediary to provide the benefit?

Mr. DURBIN. This is a Medicare delivered benefit through the Medicare agency.

Mr. SANTORUM. So there is no intermediary. The plan is actually run—unlike the current Medicare plan, it is going to be run by the Federal Government without an intermediary?

Mr. DURBIN. If the Senator will allow me to consult with the expert.

Mr. SANTORUM. I am happy to.

Mr. DURBIN. I guess the difference is, we don't divide it into 10 regions when it comes to Medicare.

Mr. SANTORUM. It is provided through an intermediary, which is the exact same delivery mechanism of the fallback plan in this bill.

Mr. DURBIN. The difference is this: The difference is negotiating lower costs for prescription drugs. And in this situation, it is my belief that this underlying bill does not. The reason the Stabenow amendment was defeated the other day, the reason there is opposition here, is, once you put Medicare in the picture on a national basis, bargaining for lower prescription drug prices, you are more likely to succeed and the drug companies are more likely to have to reduce their costs.

I think that is why the pharmaceutical companies don't particularly care for my approach and the reason many people have opposed it here. But from where I am standing, if my interest is in the senior citizens of America having the lowest prescription drug prices and our giving a helping hand as much as we can, rather than the bottom line profits of prescription drug companies, I think this is a much more advisable approach.

I reserve the remainder of my time.

Ms. MIKULSKI. Mr. President, I rise in strong support of amendment No. 994 from my colleague from Illinois, Senator DURBIN. The MediSAVE amendment would provide a vastly superior Medicare prescription drug benefit to our seniors. But I am also disheartened. This is not the bill we are debating. I wish it were.

The MediSAVE amendment meets all of the principles I laid out for a Medicare prescription drug plan. In an earlier statement, I outlined the principles that I would use to grade any Medicare prescription drug plan. I think the MediSAVE plan gets an A. I commend Senator DURBIN for his hard work on this plan.

I have five principles for a prescription drug benefit.

1. The cornerstone must be Medicare. I am opposed to the privatization of Medicare. Any prescription drug benefit that relies on the private sector must be in addition to, not in lieu of, traditional Medicare. Seniors must not be forced to leave the Medicare system they trust to get the prescription drugs they need.

2. Voluntary. No one should be coerced or forced into a private program or forced to give up coverage they currently have.

3. Affordable. The benefit must be affordable. That means a reasonable premium and copayment.

4. Universal and portable. The benefits must be available to all seniors, regardless of where they live. And all seniors must have the same benefit, and be able to take it anywhere they go.

5. Meaningful. The benefit must cover the drugs your doctor says you need—not what an insurance executive thinks you should get.

How would the MediSAVE plan benefit seniors?

MediSAVE would create a more meaningful benefit. It would have no deductible for drug coverage. It would have a guaranteed premium of $35 per month. Rather than having to pay 50 percent of their drug costs covered, under this plan seniors would have to pay 30 percent of those costs. That adds up to a big savings for seniors, many of whom live on a fixed income. MediSAVE would also take into account the amounts that employers contribute toward retirees' drug costs which will help millions of seniors keep the employer-sponsored health care they earned. But most importantly, MediSAVE would deliver the prescription drug benefit through the Medicare that seniors trust.

I believe the Durbin amendment is a great improvement over the bill we are debating. I urge all my colleagues in supporting this amendment.

Mr. JOHNSON. Mr. President, today I join several of my colleagues to urge Members of the Senate to vote in strong support of the ''Medicare Savings Alternative that's Voluntary and Equitable,'' or MediSAVE amendment. I thank Senator DURBIN for working hard to create an amendment which will make this Medicare prescription drug package a meaningful benefit for seniors across this country.

I have been troubled over the course of this debate on many fronts. There are numerous holes in S. 1 that many of my colleagues have tried to fill. Many of my colleagues have offered targeted amendments to address this bill's specific flaws. So far, we have tried to put some reasonable limitations on the premium levels that can be charged to beneficiaries. We have tried to eliminate the coverage gap that will hit seniors hard in the fall of 2006. We have tried to extend the fallback period to two years to provide more stability to seniors living in areas where managed care is just not likely to work. We have attempted to ensure that the 37 percent of employers that are estimated to drop their retiree coverage would not do so. And all of these attempts have been unfruitful, due to the resistance of Members on the other side of the aisle.

We have tried to make this a better bill, and while we have had success on a few cost containment amendments, we have come up short on many of these other critically important provisions. Seniors in my home State will be scratching their heads in 2006, wondering where their affordable, comprehensive Medicare prescription drug benefit is. This is why I am a cosponsor and supporter of the MediSAVE amendment. This amendment will provide seniors with a real benefit, one that allows seniors to get their drug coverage through traditional Medicare, not forcing them into plans to get it. It has no deductibles, limited cost sharing and no coverage gap. It addresses a blatant omission in this bill to deal with the skyrocketing costs of prescription drugs in the U.S. It allows the Federal Government to utilize its bargaining power to purchase prescription drugs at reasonable prices, rather than providing a blank check to drug manufacturers as is planned under the current bill.

Let's try and make this the best bill possible. This amendment may require us to allot some additional funds down the road, but aren't our seniors worth

it? Isn't the security of average seniors, those who have worked hard all their lives to make this country what it is today equally, if not more important than big tax cuts for the elite? I urge my colleagues to support this important amendment today.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. SANTORUM. A couple of points, Mr. President. The Senator from Illinois said people prefer having the Government run this program and administer this program. I know the Senator doesn't like top-down command and control, but it is what it is. It is a one-size-fits-all Government benefit.

A survey was just done a few days ago that said voters trust private plans over Government to provide health benefits by a margin of 54 to 34, when it comes to providing medical and pharmaceutical benefits. So the American people are used to dealing with private sector entities when it comes to health insurance, and they are very comfortable to have them provide services. And, in fact, arguably even the Medicare system that the Senator from Illinois has put forward is going to be run—the drug benefit is going to be administered by a private sector entity. It will be a company that will be contracting through a Medicare agency to provide these services. The difference is—this is the real key difference between what we want to do and what the Senator from Illinois wants to do, one of them—that we want to have these private sector entities that we were contracting with to bear some of the risk of insurance.

Again, I repeat that the importance of having these private sector entities bear some of the risk of insurance is, if they are bearing the risk, and if they don't administer this program effectively, it is going to cost them money. So they are going to probably do a little better job of administering that program than if they are simply being paid a fee to write checks or collect fees. So we believe having a shared risk with the private sector and the public sector getting together to use the best of the private sector, which is to be able to have good beneficiary relationships and to go out and try to solicit—remember, if you are a private sector contractor, you have competition. You have to treat your beneficiaries well or they can go to the other player. Your ability to sign up beneficiaries will be diminished if you are not providing quality services.

Under the Senator's plan, there is one administrator, no incentive to save money, no incentive to be customer friendly. It doesn't matter because they have no place else to go. You can take it or leave it. If you have competition and you allow people to go somewhere else, they have an obligation not only to be better at providing services but they have an obligation, if they want to keep these beneficiaries in their program, to provide good services, quality services, to be responsive—not be open, as a lot of these organizations are, from 8:30 to 4:30, and if you have a problem, you have to call on Monday morning.

A lot of these ministerial organizations, again, have no risk involved. The beneficiary has no place else to go. They have no incentive to save money. So why not just basically save money on their side, cut back on what it costs to administer this program, and get paid the same fee. They can save a little money that way, and they have no chance of losing anybody.

I think having some incentive to provide quality services and to try to save money because they have some stake in it is a very important component of delivering better services for the consumer and a better product for the taxpayer. We keep coming back to this, and we seem to overlook it.

Millions of Americans are paying their hard-earned tax dollars for this benefit. We have an obligation to make sure the money is effectively spent. I think we have an obligation to put into place systems that are more efficient than the current system—more efficient not from the standpoint of how much it costs the Government in administrative costs. That is one of the things I hear, that this is much more administratively effective than it is for these other private plans. Well, if all you do is pay bills, and you don't worry about how much is being used, you don't worry about the quality or about anything else, all you are doing is writing checks in Baltimore or writing checks to companies like Blue Cross plans who are the intermediary, then it is pretty cheap. But if what you are doing is trying to coordinate care to try to make sure that quality is imbued through the system, if you are trying to actually provide a quality service, it is probably going to cost a little bit more. I think most people believe that is a good tradeoff, plus you have the competitive angle, which I argue could actually save money.

So while I respect the Senator from Illinois and the fact that he has put forth his amendment, it is, in fact, a straight extension virtually of the traditional Medicare delivery services. It is not $400 billion; it is $570 billion. It is $170 billion more than what we all have agreed upon in the budget to provide for a prescription drug benefit.

The American public has been very clear about this. Yes, they want prescription drug benefits for seniors, but they want those benefits focused on those who are lower income, who cannot afford it, and those who are high users of prescription drugs because of disease or chronic illness. So what we have done in this bill is to do that. They also want a fiscally responsible alternative. They want a fiscally responsible plan. In fact, in surveys over the past several years, they were asked a simple question: Are you for a $400 billion Medicare prescription drug plan or are you for an $800 billion Medicare prescription drug plan? Overwhelmingly, believe it or not, they are for a $400 million plan. The American public realizes there is not just an endless pot of money that is going to be available to provide benefits for anybody, and they want something fiscally responsible.

There are many on this side of the aisle who would argue that what we have even in the underlying bill is not fiscally responsible; it is too much money, too much of a subsidy to too many people. But we brought this bill forward to find a bipartisan compromise. Part of that was to make sure there is—and there is—a $389 billion drug benefit in this bill. There is a few billion dollars to help these PPOs get set up and organized—literally, I think, seven. So there is 380-some-billion-dollars for the drug benefit, which is one objective we want to accomplish.

The other objective this side of the aisle would particularly like to see is to have choices for seniors—the private-public partnership which we believe are so important to improve quality and efficiency for the taxpayer. We are spending only $7 billion on that. That is a paltry sum compared to this big expansion of the drug benefit. We think that is important. The Senator from Illinois would disagree with that. It is a very different point of view.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, I say to my friend, thank you for expressing your point of view. You are the first person to speak on it in opposition. I hope you don't carry the day, but you might.

It is interesting that some are fiscal conservatives and deficit hawks when it comes to prescription drug benefits, but where were these voices during the tax cut debate? We were sunsetting tax cuts right and left, creating the biggest deficit in the history of the United States, and I didn't hear a word from the deficit hawks.

When it comes to helping senior citizens paying for drugs, we have to be responsible. This amendment is responsible. It is sunsetted. We have a report from CBO which says that. The $570 billion does not take into account the fact that this is sunsetted in 2010. It works within the $400 billion.

The second issue raised here is that there are people—and I think my friend from Pennsylvania is perilously close to this coalition—who don't care much for Medicare. They don't think it is a very good program. Well, the vote is in on Medicare, and it is 88 to 12. Eighty-eight percent of the people who had a chance to move out of Medicare didn't do it. They stayed. I hope you will vote for the MediSAVE amendment.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. STEVENS. Mr. President, I ask unanimous consent that I be recognized for 30 seconds.

The PRESIDING OFFICER. Without objection, it is so ordered.

MEASURE HELD AT THE DESK

Mr. STEVENS. Mr. President, I have a resolution at the desk. I ask that it be held at the desk so that I might be able to clear it this evening. It pertains to my great friend who is now 86. He was the first person to pick up the news of the World War II attack on Pearl Harbor. He is now getting along in years. We are going to honor him on Friday night, and I would like to have this resolution adopted by that time.

I thank the Chair.

Mr. REID. Mr. President, have the yeas and nays been ordered on the Durbin amendment?

The PRESIDING OFFICER. They have not.

Mr. REID. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

Mr. SANTORUM. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. There is a pending request for the yeas and nays.

There is not a sufficient second.

Mr. SANTORUM. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to amendment No. 994. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL), the Senator from Illinois (Mr. FITZGERALD), and the Senator from Arizona (Mr. MCCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. MCCAIN) would vote ''yea''.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY), the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 39, nays 56, as follows:

[Rollcall Vote No. 245 Leg.]

YEAS—39

Akaka	Byrd	Dayton
Bayh	Cantwell	Dodd
Biden	Clinton	Dorgan
Bingaman	Corzine	Durbin
Boxer	Daschle	Edwards
Feingold	Landrieu	Pryor
Graham (FL)	Lautenberg	Reed
Harkin	Leahy	Reid
Hollings	Levin	Rockefeller
Inouye	Lincoln	Sarbanes
Johnson	Mikulski	Schumer
Kennedy	Murray	Stabenow
Kohl	Nelson (FL)	Wyden

NAYS—56

Alexander	Crapo	McConnell
Allard	DeWine	Miller
Allen	Dole	Murkowski
Baucus	Domenici	Nelson (NE)
Bennett	Ensign	Nickles
Bond	Enzi	Roberts
Breaux	Feinstein	Santorum
Brownback	Frist	Sessions
Bunning	Graham (SC)	Shelby
Burns	Grassley	Smith
Carper	Gregg	Snowe
Chafee	Hagel	Specter
Chambliss	Hatch	Stevens
Cochran	Hutchison	Sununu
Coleman	Inhofe	Talent
Collins	Jeffords	Thomas
Conrad	Kyl	Voinovich
Cornyn	Lott	Warner
Craig	Lugar	

NOT VOTING—5

Campbell	Kerry	McCain
Fitzgerald	Lieberman	

The amendment (No. 994) was rejected.

AMENDMENT NO. 1000

The PRESIDING OFFICER. There are 2 minutes evenly divided before the next vote.

The Senator from New York.

Mrs. CLINTON. This amendment is critical to the functioning of the plan now under consideration. If we are going to move toward creating a marketplace for drugs, then we need information about which drugs work better for the money they cost. Last December, we found out through a study by the National Heart, Lung and Blood Institute that the newer drugs such as calcium channel blockers and ACE inhibitors which cost 30 to 40 percent more than diuretics were not as effective for treating high blood pressure. There is much information about this.

My amendment is very simple. It asks NIH to do studies comparing drugs to give that information to physicians and to consumers so they can make good decisions in the marketplace. It also asks that we synthesize the literature out there, make it available over the Internet. If we are going to have a marketplace for drugs, the information about which drugs are more effective should not be the sole property of the great companies. Physicians, clinicians, consumers, and patients need that information. This will help us do that.

I hope you will support this amendment. It does not have any cost attached to it. It is about getting information to the people who will make the decisions about which drugs should be used when it comes to making these choices we are trying to provide for people.

Mr. ENZI. Mr. President, I rise in opposition to amendment No. 1000, offered by Senator CLINTON. This amendment would give the Federal Government new funding to manage comparative effectiveness studies of pharmaceuticals. While this may sound good on the surface, this amendment would end up as a tool for health care rationing by bureaucrats in Washington.

Comparative effectiveness analysis in the private sector can provide useful information. However, giving the Federal Government the power to make national determinations based on one or two comparative studies is dangerous, because these decisions would affect tens of millions of patients who rely on the Government for their health insurance.

This amendment would get the Federal Government even further into the business of making medical decisions. It would promote one-size-fits-all medicine.

Studies conducted under this amendment may be misused by the Centers for Medicare and Medicaid Services or other bureaucracies by encouraging broad and simplistic decisions about which patients should have access to new medicines.

Even worse, these comparative effectiveness studies might become a rigid benchmark adopted by payers across the health care system. Private insurers already look to Medicare for decisions on medical procedures and technologies, and doctors are already concerned about the way Medicare conducts those determinations.

Private insurers copy many of Medicare's limitations on the procedures and therapies from which physicians choose in determining the best course of treatment for their senior patients. If we extend this level of bureaucratic control to drugs and biotechnology, the Government's decisions about medical access would end up being imposed on many more patients than just Medicare beneficiaries.

In considering this amendment, we need to keep in mind that innovations in health care are usually incremental. This applies to drug developments, where ''next-generation'' advances yield incremental benefits compared to existing treatments.

Government studies on comparative effectiveness may fail to recognize or value fully these advances. If we had a Medicare drug benefit in place today that only paid for so-called ''breakthroughs'' in pharmaceuticals, we may not have reaped the benefits of many antibiotics, antivirial drugs, non-steroidal anti-inflammatory agents, and ''beta blockers'' for controlling high blood pressure.

Finally, centralized comparative analysis runs the risk of overlooking the value of specific medicines for individual patients. Prescription medicines to treat a specific disease or condition are different from one another. That is why patients and doctors need choice.

Population-based comparative effectiveness determinations such as those proposed in this amendment may fail to recognize important differences in the way individuals and sub-populations respond to different drugs and drug combinations. As a result, such studies can discourage access to new

medicines that can benefit many patients with diseases and conditions such as hypertension, diabetes, heart disease and mental illness.

Comparative effectiveness studies are not dangerous, and we ought to encourage more and better studies on the relative merits of various drugs for various people. What concerns me is how this amendment would put the Government in control of these studies.

If one branch of the Government is conducting these broad studies, and another branch of the Government is paying for the drugs that your loved one needs, it is just a matter of time before the results of the broad studies are imposed upon the freedom that your family doctor has to choose the best drug therapy for your loved one.

Coming from Wyoming, I am used to fighting against one-size-fits-all solutions from the Federal Government. I certainly cannot support an amendment that would impose such an approach on something as important as healthcare for seniors who rely on pharmaceuticals to make their lives better.

I urge my colleagues to vote against this amendment.

The PRESIDING OFFICER. Who yields time?

Mr. GRASSLEY. Mr. President, I appreciate the intent of the amendment. However, I have significant concerns and must oppose it. The research provided by this amendment is unnecessary. It duplicates, in fact, existing authority in the HHS.

More importantly, this amendment contains two damaging provisions. It directs the Food and Drug Administration to include information coming from these studies in approved product labeling, effectively taking the sole authority of the FDA to regulate prescription drug labeling and giving it to other, nonexpert sources.

This amendment also changes the fundamental research mission of the National Institutes of Health.

Further, these changes have not been considered by the Health, Education, Labor, and Pensions Committee, which has jurisdiction over these programs.

This amendment is unnecessary. I urge my colleagues to defeat it.

Mrs. CLINTON. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the amendment.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL), the Senator from Illinois (Mr. FITZGERALD), and the Senator from Arizona (Mr. MCCAIN) are necessarily absent.

I further announce that if present and voting the Senator from Arizona (Mr. MCCAIN) would vote ''yea''.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea''.

The PRESIDING OFFICER (Mr. SUNUNU). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 43, nays 52, as follows:

[Rollcall Vote No. 246 Leg.]

YEAS—43

Akaka	Durbin	Lincoln
Bayh	Edwards	Mikulski
Biden	Feingold	Murray
Bingaman	Feinstein	Nelson (FL)
Boxer	Graham (FL)	Nelson (NE)
Byrd	Harkin	Pryor
Cantwell	Hollings	Reed
Carper	Inouye	Reid
Clinton	Johnson	Rockefeller
Conrad	Kennedy	Sarbanes
Corzine	Kohl	Schumer
Daschle	Landrieu	Stabenow
Dayton	Lautenberg	Wyden
Dodd	Leahy	
Dorgan	Levin	

NAYS—52

Alexander	DeWine	Miller
Allard	Dole	Murkowski
Allen	Domenici	Nickles
Baucus	Ensign	Roberts
Bennett	Enzi	Santorum
Bond	Frist	Sessions
Breaux	Graham (SC)	Shelby
Brownback	Grassley	Smith
Bunning	Gregg	Snowe
Burns	Hagel	Specter
Chafee	Hatch	Stevens
Chambliss	Hutchison	Sununu
Cochran	Inhofe	Talent
Coleman	Jeffords	Thomas
Collins	Kyl	Voinovich
Cornyn	Lott	Warner
Craig	Lugar	
Crapo	McConnell	

NOT VOTING—5

Campbell	Kerry	McCain
Fitzgerald	Lieberman	

The amendment (No. 1000) was rejected.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I believe there is a unanimous consent request that the next amendment be the Grassley-Baucus amendment. I think they are working on that. I ask unanimous consent to make a statement on the bill for not to exceed 20 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. NICKLES. Mr. President, first I want to make a couple comments on the bill, then talk about a couple amendments we will be working on. I wish to compliment first Senator FRIST and Senator GRASSLEY, Senator BAUCUS for getting us here. I also compliment President Bush because he has been pushing for us to expand Medicare to include prescription drugs. I happen to share that goal so I compliment him because here we are.

I believe in the next 24, maybe 28 hours, we will eventually pass a Medicare bill that will provide prescription drugs. That is our objective. That is a good one. I hope we will be successful.

I also hope we will pass a bill that is affordable. I am not sure the bill before us now meets that definition. I want to talk about what is in the bill and maybe some of the challenges we have confronting us, but again I want to compliment the chairman of the Finance Committee.

This year we did have a markup in the committee, and we did report out a bill. I didn't vote for it. I will explain why I didn't vote for it. But I hope to vote for a bill either on the floor of the Senate or as the bill comes out of conference.

At least we had a markup. I am on the Finance Committee. The Democrats were in control of the Senate last year. We didn't have a markup in the Finance Committee. We basically had a markup on the floor of the Senate. We spent some time on it, several weeks, but we didn't pass a bill. It didn't become law. It was very frustrating. We didn't do the normal process.

This year I don't quite agree with the final outcome as it came out of committee, but at least we had a chance. We had a bill. We had a markup. We considered dozens of amendments. We reported out a bill.

Now, the Senate has been on this bill for 2 weeks. We have considered a lot of amendments. We will consider more both tonight and tomorrow. So my compliments to the leader and to the chairman of the committee for getting the bill to where we are.

Let me talk a little bit about the current status of Medicare. Medicare has big challenges confronting it today. It is a very popular program, but it is a program that really can and could and should be improved. It is a very expensive program. The cost of Medicare has more than doubled since 1990. In 1990 we were spending $100 billion. Today we are spending over $200 billion. But that doesn't show the liabilities that we already have in the system.

Medicare has a shortfall of $13.3 trillion. By ''shortfall'' I mean benefits that have been promised that are not funded, not paid for. That is an enormous sum of unfunded liability. The total unfunded liability of Social Security is $4.6 trillion. The total debt held by the public is $3.6 trillion. So we are looking at Medicare's shortfall actually exceeding or tripling the total amount of debt held by the public.

I heard many colleagues, when we talked about raising the debt limit, say we should not do this. What we are doing on Medicare and the bills we are considering right now will increase the unfunded liability in Medicare probably by $4 or $5 or $6 trillion, greater than the total Social Security shortfall and far greater than the debt held by the public. This is an enormous expansion of benefits we are saying we will pay for. People need to know it.

Is it affordable? Just to pay for the Medicare shortfall today according to the 2004 budget of the U.S. Government it says to pay the actuarial deficiency as a percent of discounted payroll tax base—we would have to increase Medicare taxes 5.3 percent on top of the 2.9 we are already paying just to pay for

this $13.3 trillion. We would have to more than double the tax. Actually, it would be, in effect, almost tripling the Medicare tax which is presently 2.9 percent on all payroll, not just on the Social Security base of $80,000-some. This is on all payroll. You would have to increase it an additional 5.23 percent, according to Government submissions and budget submissions, to cover the 75-year projections.

Social Security would only have to be raised 1.87 percent. So, again, it shows that at least actuarially, Medicare is in much worse shape, about three times worse shape as Social Security. And that is without us passing additional benefits on top of it. So I want my colleagues to be aware of that. This is a very unstable house, and we are getting ready to build another deck on top of it. That is the reason I am raising some of these concerns.

I want our colleagues to be aware. Maybe we will do it anyway. Maybe it is the popular thing to do. But at least I don't want it to go without saying: Wait a minute, did anybody not pay attention to the fact that these are enormous liabilities. They are going to be very expensive and somebody is going to have to pay the bill sometime. In the past, we paid for Medicare with the payroll tax. That has had some limiting effect. When trust funds were drawn down, people said: We have to do something. So there would either be a tax increase or there might be some reforms.

We passed Medicare reforms in 1997. We spent a lot of the last few years maybe undoing some of those reforms, but it did save money. Now we are getting ready to expand Medicare at a greater percentage than it has ever been expanded since its creation in 1965.

Again, I favor making significant improvements in Medicare. I find the system to be very obsolete in the benefits it provides. It has serious shortfalls. Medicare doesn't provide prescription drugs. It should. Medicare doesn't have preventive care, ordinary, routine checkups in many areas. It should. A good health plan certainly would do that.

It has a hospital deductible of $840. That is way too high. Then it has a different deductible for doctors. They should be a combined deductible, and it should be much lower than $800 and $900 combined.

It is a system that leaves a lot to be desired. It doesn't have catastrophic coverage. So if a person gets really sick and they are in the hospital for a long time, after a certain number of days Medicare doesn't pay it. That doesn't make sense. You really should have insurance to pay for something you can't afford to pay for, and this system doesn't do that.

As a matter of fact, a lot of our health care system, in my opinion, is broken because we end up insuring for relatively almost first-dollar costs, and we don't insure in some cases for the really expensive things or at least that is the way Medicare is. That is not a good example. We should change that. You should insure for those events that you can't afford. You shouldn't be insuring for ordinary, routine things that obviously individuals can pay for.

I make the analogy to automobiles. You should insure for the accidents, the collisions, for something very serious, something very expensive. You should not insure to fill the car up with gasoline or to change the oil.

In health care costs, I am afraid we insure for almost everything, and that greatly increases the cost. My major complaint with the bill before us is that I want to improve and expand and modernize Medicare. I want to improve Medicare. My mother is on Medicare. I want her to have a better health care system. I want her to have a health care system that is comparable to what we have for Federal employees. I would like for senior citizens to have a good base plan and then be able to choose any of a variety of other plans they wish to have—keep what they want or they can choose something better. They can have an integrated benefit system.

Unfortunately, I am not sure that is what we are going to pass probably tomorrow night. The bill we have before us—the reason I voted against it in Finance Committee, and I may vote against it on the floor of the Senate, is because I find the bill very expensive and very light on reforms. It doesn't make as many reforms as I would like and it is expensive on the subjects. I have mentioned we would have to increase payroll taxes by 5.23 percent just to make up for the shortfall. That doesn't include the drug benefit. I have been told by tax estimators that you would have to add another .7 or .8 percent to pay for the drug benefit we are adding.

I am concerned that the drug benefit we are adding will be much more expensive than anybody estimates. The budget resolution says it was $400 billion. I compliment the chairman and the House, who are staying with the $400 billion estimate, but I would project that many years from now, it will not be a $400 billion expansion; it will be much closer to $800 billion by the end of 10 years.

I am making this prediction and I mean it. This is not just a guess. Maybe it is a little more than a guess, but I think ultimately you will see a few things happen, and I will talk about the basic benefit we are offering and why I think the cost will exceed our estimates.

In the first place, the subsidies are very large indeed. For people below 160 percent of poverty, the Federal Government is going to pay almost all the drug expense. For individuals in this income category, as estimated by CMS—they estimate usage—drug usage is $3,200 for people below poverty, and then a little less than $3,000 for incremental levels above that. But the beneficiaries at the lower income levels pay very little. The Government pays almost all of it. I have heard some people say, wait a minute, you want to change that. I am questioning, is this affordable? For income levels in this category, the lowest income, the poorest of our seniors, an individual would pay $82 and the Federal Government would pay $3,214. An individual pays 2 percent and the Federal Government pays 97½ percent. That is a very high ratio.

The next level is not much different. The individual would pay 5 percent and the Federal Government pays 95 percent. The next level up—and this is with an income up to about 150 percent of poverty. For a couple, the income is about $19,576. So the Federal Government would pay 90 percent and the individual would pay 10 percent. Those are very generous subsidies.

Looking at the estimate, I would guess that if the Federal Government is going to pay 97 or 95 or 90 percent, you will have drug utilization go up maybe well beyond these figures.

These figures come from CMS, and they say those are figures for people with insurance, but I would guess the people who are on this level—Medicaid eligibles, and many States have a lot of restrictions on the number of prescription drugs they can have. In many States you are limited to three a month. If the Government is paying 97½ percent, and there is not a limitation of three or so many a month and it doesn't have the limitations of the States because the States are requiring cost sharing of 30, 40, or 50 percent, my guess is it will go up dramatically.

I think in all levels utilization will go up dramatically. Maybe I am wrong. I am concerned about it at least for these lower income levels, the income levels below 160 percent of poverty. The bill we have before us is probably too generous, but maybe not affordable. I hope I am proven wrong. But I have been in business. I took over management of a company when the company had a health care plan where the company paid 100 percent of health care premiums and costs. That really wasn't sustainable. I think a lot of other businesses found out, wait a minute, that is not affordable. Most businesses started putting in 80/20 ratios, where the beneficiary paid 20 percent, or 10 percent. I don't mind lower income people having to pay a smaller copay; I am fine with that. But I think we are starting out so generous that it will encourage overutilization, and costs will explode. Once you start out with a percentage like that, it is hard—I can see starting at 80 percent and maybe going to 90, but I don't see going from 97 percent to 90 percent. A future Congress may be forced to make those decisions. It may not be affordable or sustainable. The demands may be so great that it is not sustainable.

Is this a good deal for seniors? Certainly, people on the low end, below the 100 percent of poverty level, with an income of $9,600 and, for a couple,

$13,000, the copay is $82 and they will receive almost $3,300. Under present law, according to CMS, they pay $734. So the amount they pay goes down almost 80-some-odd percent. This is a great deal for low-income if we can afford it. The next level would pay $150. Currently, they are paying almost $1,200. Again, they are only paying about one-eighth of what they were paying previously and getting a very nice return. This is 136 to 150 percent of poverty—that would be for individuals with incomes, and for a couple it would be up to $19,500. They would pay only $343. Presently, they are paying $1,300. So it is a big improvement for them, and they are receiving about $3,000 in benefits.

So there is a very good and generous benefit—maybe the most generous benefit anybody could propose is for incomes below 160 percent of poverty. Above that, it is not such a good benefit. I have heard some colleagues complain it is not so good for individuals with incomes above 100 percent of poverty, with incomes of about $15,400 or, for a couple, of about $21,000. Above that level, the formula changes. Then they have to pay a premium of $35 a month. Then they have a deductible of $275 a month. Then they receive a drug benefit after they get through the deductible of 50 percent up to $4,500. Then above $4,500, for the next $1,300, they would have to pay 100 percent. Above that level, they get 90 percent.

Well, that is not a great drug benefit. It is not great. It is OK, maybe, but it is not as good as a lot of plans. Looking at a lot of plans people now have, at levels like this, an individual for this plan today would be paying, under the new bill, $1,600. The individual today is only paying about $1,162. They would pay about an extra $500 for maybe a similar benefit, and it is estimated they would receive a total of about $3,000. Actually, if you look at the upper income—above $21,000 for a couple—in every category they pay more under the proposal we have before us than they are under current law. So it is not a real good deal for them. It is voluntary. Maybe they will drop out. If they drop out—it depends on the health status, but if they are healthy, it may make things worse for the taxpayers. They may not help subsidize others who are less healthy. It is a very generous benefit for lower income, below 160 percent of poverty, and it is not such a good deal for upper income.

A lot of people above 160 percent of poverty have drug coverage. A lot of people below that have health care. Below 160 percent, you cannot beat this deal. Above it, you can beat it. A lot of people have better. You say what do you mean? They might have a union plan. We had amendments to make sure those were made whole. We wanted to subsidize them to make sure they didn't lose a dollar. The CBO estimated that 37 percent of the people who have private health care coverage are going to drop them and go into this Government plan. They have health care through their employer, and their employer is going to say if Uncle Sam is going to do this, why don't you get your health care and drug benefits through Uncle Sam instead of through the employer.

A lot of employers are struggling to pay for retirees' health care benefits, so they would welcome this. So you will see a lot of companies dumping or dropping their health care coverage, even though it may well be more generous than what we have proposed before us, the bill before us in the Senate. Likewise, many States have drug programs, many of which may be more generous, not necessarily for low-income, but they have a plan, or some system, or other type of entity that we will be picking up. States were making a contribution, maybe it is a combination of State and Federal, to Medicaid. They are dropping it. Where the States were making a contribution in the past, we will be assuming that contribution. This is a big federalization, frankly, of the benefit that is provided in the public sector and private sector.

Seventy-seven percent of seniors today have some type of drug insurance. This is going to preempt most of that and say the Federal Government is going to take it over and, in some cases, not do as good as the private sector has done, maybe not even as good as most of the public sector.

Is it affordable? The estimates are it is $400 billion. I already mentioned I am concerned, at least on the levels where the Federal Government subsidies are 97 percent or 95 percent or 90 percent, that utilization will exceed expectations. If the Government is going to pay most of the cost of the drugs, my guess is people are going to say: Give me more of those drugs.

There is not a restriction that is going to say you can go to one doctor, go to this specialist for whatever ails you, you can go to another specialist for whatever ails you, and, frankly, if the Government is going to be picking up 95 percent of the drug care costs, people are going to say: Give me some of those. They are going to see the ads on TV. They may see Celebrex—it has a great rhyme to it—or see some other ad that looks good, and they say: Doctor, give me some of that. And if Uncle Sam is going to be paying 97 percent of the cost, why not? That makes your patient happy. Maybe it will work, maybe it will not.

My guess is we are going to see, where the third party or Government is paying 90-some-percent of drug care costs, that utilization will soar and that will greatly drive up the cost.

I think in the drug benefit formula where we have basically a formula above 160 percent of poverty where the Government says you pay your $35 a month and you pay your deductible of $275 and then Government will match you 50 percent up to the first $4,500, a lot of people who might have a drug annual expense in the neighborhood of $1,200 or $1,300 may say: I do not get my money back until I use or consume $1,300 worth of drugs, and I am paying a monthly premium; therefore, I am going to start taking advantage of it. If Uncle Sam is going to be paying 50 percent, I want more. So their utilization may go up and may go up dramatically. So that could increase costs.

Then we have this so-called doughnut amounts above $4,500 to where presently individuals would have to consume or pay for 100 percent up to $5,813. A lot of people are going to say we need to fill that up.

I ask unanimous consent for an additional 8 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. NICKLES. Mr. President, they are going to say we get 50 percent up to $4,500, and then it stops and we go to catastrophic, let's fill that in. The estimates were by some, if you filled that in, it would cost you another $200 billion. My guess is we are not going to do it this year, but we will do it sometime probably in the next 3 or 4 years. That will cost a bunch of money.

Then people are going to be complaining: This is really not a good deal. You get 90-percent subsidy over here but 50-percent subsidy over here. We need to make that 60, 70 percent. Frankly, that 60 percent is not high enough. Let's move that category up to 200 percent of poverty. Let's move it up higher.

When you make those kinds of incremental changes, and I know many of the advocates want to do that—they stated that. I acknowledge it, and everybody around here should acknowledge that is their desire—I expect they will be successful.

There are a lot of people who will say this is not near as good a deal as I have right now, and they are going to lobby Congress: We need a greater share; we need a greater match. Why not go 50/50? Can't we go 60/40, 80/20? Can't we fill in the donut and insure that whole amount?

When you make a few of those changes, you have a bill that is not going to cost $400 billion, it is going to cost $800 billion. In that last year, the line will be going straight up. I am concerned about that situation. I am concerned about the expense of it.

People say: What do we do to make it more affordable? Did we make some of the changes that would help make it more affordable? Did we make some of the reforms, some of which are not easy?

I have been an advocate for increasing the eligibility age, making Medicare the same age as recipients of Social Security. Right now with Social Security, you do not receive Social Security at age 65, you receive full retirement Social Security at 65 and 10 months. By the year 2022, you have to be 67 to receive Social Security.

I happen to think because people are living a lot longer and because Medicare has such enormous financial problems, we should make the Medicare-eligibility age concurrent with Social Security. Basically, by the year 2022, one would have to be 67 before receiving Medicare. I know that is not an easy vote, but, frankly, this Senate voted for it just a few years ago. We voted for it, I believe, with 62 votes. We passed it. We can, could, and should pass it again. It will save our kids a lot of Medicare taxes. That is one reform. I doubt we are going to offer that amendment, but it has been proposed and discussed, and I think it should be seriously considered.

Another amendment will be offered by Senator FEINSTEIN, myself, and Senator CHAFEE tomorrow that basically means testing Part B premiums. I will talk about Part B premiums, and it gets too confusing for a lot of people. We subsidize Medicare. Most people think we pay for Medicare just with the payroll tax.

The payroll tax, I already mentioned, is very deficient. As a matter of fact, it is 2.9 percent of all income, not capped. If somebody has an income of $1 million a year—Michael Jordan, I think, makes a little more than that—if they make an income of $1 million, they pay $29,000 a year into Medicare. Yet we are still going broke. The actuaries say we have to add another 5.2 percent on top. We have to have 8.1 percent to pay for the liabilities we currently have. That is without a drug benefit. If we add a drug benefit, we would probably need to add 1 percent on top of that.

Now we are talking about real money; we are talking about 8 or 9 percent of the liabilities in Medicare. We need to make reforms. One would be to means test Part B premiums. Payroll tax pays a lot of money, but general revenue pays a lot of money into Medicare.

To give an example, this year general revenue, not the payroll tax, general revenue coming from all taxpayers in the year 2003 will put in about $81 billion. In the year 2013, it will be $189 billion. So it more than doubles in the next 10 years, and it does not keep up.

That general revenue portion is the individual recipient pays one-fourth of Part B. This is what pays the doctors. The recipient pays one-fourth of it, and the taxpayer or the general revenue fund pays three-fourths of it. What that means is we are asking our kids to pay for three-fourths of our doctors visits.

At least for those with upper incomes we should not be asking our kids, who are maybe making $20,000 or $15,000 or $30,000, to be paying part of the doctor bills for at least the wealthier seniors. Not all seniors are low income. So the amendment we will be considering probably tomorrow evening says instead of having a 25-percent copay for beneficiaries on Part B, if your income is very high, it will be 50 percent; if it is much higher, it will be 100 percent.

I believe the levels are if an individual has an income of $75,000 and $100,000 for a couple, their percentage would increase from 25 percent to 50 percent. Likewise, for a couple, if an individual had an income of $100,000 or the couple had an income of $200,000, they would have to pay 100 percent of the premium. So we would not be subsidizing them. That would take a lot of pressure off the system.

The most recent trustee report states that SMI, that is Part B revenues, in 2002 were equivalent to about 7.8 percent of personal Federal income tax collected that year. If such taxes remain at their current level relative to the national economy, then Part B general revenue financing in the year 2077, 75 years from now, would represent roughly 32 percent of total income taxes. Now, that is staggering. About a third of all income taxes would have to be paid just to pay the Part B subsidies that we now have in the system. That is not sustainable.

My point is, we have to have a Medicare system that provides better benefits. Yes, I agree. We also have to have a Medicare system that is sustainable for future generations, for our kids and grandkids. We want to have a system they can afford.

I mention these as two reforms, and there is one other one I am going to mention. The primary reform that is in the underlying bill provides for a private sector health care plan—most of the time we call it a PPO, preferred provider organization—similar to many of the health care plans that are all across America providing an integrated structural benefit. They do not just provide drugs. They provide all health care benefits. They provide the hospital and the doctor, access to specialists and drugs. That is what is in most people's health care plans today.

That is not Medicare. We would like to update and upgrade Medicare to bring it into the 21st century so it has comparable benefits, so it can have an integrated management system, so that individuals who are in the system say, yes, they control your drugs and they control your visit to the hospital and the specialist, and you have really good quality care.

We do not have that in Medicare today. The real reform and what many of us are hoping we can do is improve Medicare so people can have preventive health care, so they can have more screenings, catastrophic, and prescription drugs all as one part of a package like Federal employees, like other health care, like a lot of the union plans that are out there today. We do not have that in Medicare today. So we are trying to make that a viable alternative to the present system.

So if some individual wants to stay in the present system, they can, but if they would like to choose a better, more modern system, more integrated system, they can do that.

I very much hope to see that the PPO model will actually become a reality that is a real viable alternative. CBO estimates that in the underlying bill only 2 percent would participate in the new PPOs. That is a failure. CMS, the Center for Medicare and Medicaid, estimates it might be as high as 42 or 43 percent. I would like for that to be the case. I think that may be overly optimistic.

I think we need to work to improve this section of the bill. I know that Senator GRASSLEY and Senator BAUCUS have an amendment to maybe make a small step in that direction, and I compliment them for it. For the life of me, I think if this is the only reform in the bill that we have, and we do not even have competitive bidding until the year 2009, that is not real reform.

I hope to be or expect to be a conferee on this bill, and I am going to work to try and see that we have real competition as a viable alternative to improve quality Medicare for all seniors. They should at least have that option. I do not see it in the bill we have right now, but I want to work to make that happen. That is one key we are hanging on for reform in the bill that is before us. We do not have Part B means testing. We do not have eligibility age. We did not make the tough decisions to help save Medicare and make it more affordable for future generations. What we are doing is basically spending a lot of general revenue money to provide benefits that frankly are long overdue.

I hope we would make some of these improvements in conference or maybe on the floor. We are going to try and make one or two of these tomorrow, and I hope that they would pass to make this a better bill.

I want to support this package. I want to pass Medicare. I want to improve Medicare for all seniors. I am afraid right now the bill is heavy on subsidies and short on reform, short on improvements, short on making real structural and substantial savings that will save the system for future generations. I want to save it for seniors today, and I want to save it for future generations tomorrow.

I will work with my colleagues both in the House and the Senate and the conference to try to achieve that objective.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. MCCONNELL. Mr. President, I begin by complimenting the distinguished Senator from Oklahoma for his remarks and his very important contribution to this debate. He is one of the most knowledgeable members of our conference on this subject. I thank him for the fine work he has been doing on this important bill.

Of course, Chairman GRASSLEY and the ranking member, Senator BAUCUS, have been doggedly pursuing this important legislation, not to mention our leader, the majority leader, the only physician in the Senate. He has had this as a top priority for the last 4 or

5 years, really for all of his term in the Senate. These individuals, along with Senator KYL and Senator LOTT, have made an important contribution in getting this legislation to the stage that we find it today.

For almost 40 years, since Medicare was created, we have debated how to help our most frail citizens acquire the miraculous but expensive prescription drugs that they need. After all the talking for decades, today we are finally acting to provide to our seniors, the poor and the fragile of our society, the financial aid and means to acquire these wonder drugs.

As we move deeper into this debate to provide Medicare assistance to those citizens most likely to need these miracle drugs but least able to afford them, some will ask, what took us so long? The question is really not rhetorical. The reason it has taken so long is the same reason why I suggest today that this Medicare debate has not been easy, nor do I believe it is preordained that a quality Medicare prescription drug and reform bill will pass this body.

The reason we have difficult work to do is because there is a riddle to Medicare drug benefits. The riddle of Medicare drug benefits is this: How can Congress take the fastest growing Federal entitlement, with the largest long-term funding gap, and add an expensive but needed new benefit without overwhelming the fiscal solvency of the program or imposing a crushing payroll tax burden? Simply put, how can we add prescription drugs to Medicare today yet still preserve Medicare tomorrow?

Yes, it is possible, and the President has solved the riddle of Medicare. To understand how, we can look to another riddle from ancient Greek mythology. Legend holds that the ancient city of Thebes suffered from a creature called a sphinx: part woman, part lion, and part bird. This creature would devour any who failed to solve the riddle of the sphinx.

The riddle asked: What animal walks in the morning on four feet, in the afternoon on two feet, and in the evening on three feet? The answer is, of course, man, said the legendary Oedipus. In childhood, he creeps on his hands and knees; in manhood, he walks upright; and in old age, he walks with the aid of a cane.

Oedipus first considered man in all stages of life, but only by considering the common cane did Oedipus find the answer. Thus, he solved the riddle, destroyed the sphinx, and ended his people's suffering.

I suggest a similar approach to the riddle of Medicare. We must consider Medicare as it relates to our people in all stages of life—yes, as seniors, but also as working adults and as children. The key is to consider the common cane, the ageless symbol of age, the cane. When the Government buys this quad cane through Medicare, it pays $44 for this cane. When the Government buys the same cane through the Veterans Affairs Department, it pays $15. Let's run that by us one more time. Two different departments of the Government: Medicare buys the cane and pays $44. Veterans Affairs buys the cane and pays $15. The same cane, same Government, same patient but different Government program—$44 versus $15.

Solve this and we solve the riddle of Medicare. Solve this and Medicare prescription drugs will not come at the expense of Medicare preservation.

The General Accounting Office has documented how Medicare habitually overpays compared not just to what the private sector pays for medical goods but what other parts of the Government pay for medical goods. Medicare pays $12 for a catheter that most Federal Employees Health Benefits Plans pay only $1. Medicare pays $9 for an infection drainage bag while Blue Cross/Blue Shield typically pays $2.25. Yet overpaying is only part of the problem. Fraud and abuse costs Medicare as much as $12 billion per year. Over 10 years that would equal almost one-third of the $400 billion we dedicate to Medicare in this bill we are considering.

Paperwork and redtape also waste Medicare dollars. With 110,000 pages of regulations, hospitals hire literally armies of clerks to handle everything but medical care. Some doctors are forced to spend as much time on Medicare patients' paperwork as they do caring for the Medicare patient.

Medicare's regulatory burden is so great that the world-renowned Mayo Clinic requested not to be named Medicare Center for Excellence because the paperwork and redtape linked to such a distinction exceeded the benefit of any additional funds, as well as the honor itself.

These are the aspects of Medicare that so many want to change yet so many seem to ignore.

If we provide these drugs without fixing how we continuously overpay for this cane, we will fail to fix Medicare. Medicare prescription drugs for our parents will come as Medicare preservation for our children. There is an answer to the riddle. In a word, it is reform. That is what the President's plan is all about and the key to the work we began earlier this week: Provide prescription drugs for our parents and ensure preservation for our children.

The President has sent us the right plan at the right price. It will strengthen and modernize the entire Medicare system.

As we continue to work on this modified version of the President's plan we must keep in mind that while the President likes what we have done so far, he wants us to do more. That is a good goal for all. This is not a political game. This is for real. This is not about the next election; it is about the next generation. This is not just about prescription drugs; this is also about preservation.

Yes, this is about our parents and grandparents, but this is also about our children and grandchildren. If we keep in mind all of our people and all that is at stake, I am confident we will produce a bill we can all be proud of and that the President can sign. That challenge continues today.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. HARKIN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 991

Mr. HARKIN. Mr. President, last week, I believe it was Friday, a number of amendments were laid down, one of them being an amendment that I offered. It is cosponsored by Senator SMITH of Oregon. It has been sitting there all week. I have not had much of a chance to say anything about it.

I thought, since there is a lull on the floor, I might take an opportunity to talk about that amendment and what it does, just so, when it comes up for a vote, I will not have to take a lot of time then to talk about it.

The amendment, I would say at the outset, is exactly the same as President Bush requested in his 2004 budget but for one small change. President Bush's budget requested $350 million a year for 5 years, under Medicaid, to get people with disabilities out of institutions and nursing homes and into community living.

The problem is that the cost of this to the States is very high for the first year. You can understand and appreciate, taking people out of an institution, out of a nursing home, means the State has to find housing; it has to find, perhaps, qualified personnel to help, maybe attendant services. So there are a lot of preliminary things a State has to do in order to provide for this transition from an institution to community-based living. Many States simply cannot afford it.

The good news is that States want to do this because it has been shown, in the States that have done this already, they save a lot of money. It is much cheaper to have a person with a disability in a community-based or home-based setting than in an institution or a nursing home—much cheaper. In fact, in a couple or three States that have already done this, we have had savings of over $40 million or $50 million a year to those States.

Again, the hurdle is that first year, getting people out of these institutions and into community-based living. What the President had requested in his budget was $350 million over 5 years as an enticement to States to do this. What the Federal Government would do is it would provide 100 percent of the funds per Medicaid beneficiary for that first year. After the first year, then the State would go back to the Federal/

State Medicaid match that the State had before. So, let's say a State had a 60/40 Federal/State match on Medicaid right now. During the first year, the State would have to come up with no money; the Federal Government would take 100 percent, would provide 100 percent. The State could use that money, then, that extra money, to set up community-based living systems for people and institutions and nursing homes. After that first year, then the State would go back to the 60/40 split it had before.

That is what this amendment is. It is called ''Money Follows The Person,'' and that is what President Bush called it in his proposed budget also.

What our amendment would do would be to provide, in the 5-year program, $300 million in the first year and then $350 million in each of the following 4 years. Then that would be the end of it. It would be 2004 to 2008.

Again, it has been 13 years since the Americans With Disabilities Act was passed. We will celebrate that on July 26 this year. In the Americans With Disabilities Act, we as a Congress, as a country, said no to segregation of people with disabilities. The Americans With Disabilities Act said: We are going to integrate people with disabilities into our society. No longer are we going to exclude and segregate them. However, our Medicaid Program today, 13 years later, still says yes to segregation.

Here is what I mean by that. Recent data indicates that 70 percent of Medicaid funds are spent on institutional care and only 30 percent to pay for community services. The thrust of our Medicaid spending today is for institution-based care. Our Medicaid system kind of flies in the face of the Americans With Disabilities Act in which we as a country committed ourselves to desegregate people with disabilities, fully integrating them in our society.

I have been trying for the last 10 years to get this change made. It is a bipartisan effort. I am not the first to do this. Others have tried it also. I do commend President Bush for putting it in his budget proposal for this year. It is the right thing to do, and I commend the President for doing that.

Now, again, I want to make it clear, this amendment is about choice. No one will be moved out of an institution who does not choose to be moved. This is not mandatory. Under this amendment, a State will be required to ensure that individuals and their representatives have the necessary information to make an informed choice as to whether they want to live in community-based situations or whether they would prefer to remain in an institution.

Now, again, regarding the offset, our amendment is fully offset by a Medicare secondary payer provision that is supported by the Department of Justice and was included in the House bill.

Mr. President, I have a letter, dated June 17, from William E. Moschella, Assistant Attorney General. It is to the chairman of the House Committee on Energy and Commerce, Congressman TAUZIN. The letter states:

This is to advise you of the Department's support for a provision in the Medicare Prescription Drug and Modernization Act—

Which we are about now—

set forth in Title III, Section 301, which would protect the integrity of the Medicare Trustee Fund by clarifying that Medicare must be reimbursed whenever another insurer's responsibility to pay has been established. The Section is consistent with the litigation positions taken by this Department and the Department of Health and Human Services in numerous court cases.

So the Department of Justice, speaking for the administration, is in favor of this offset.

Mr. President, I ask unanimous consent to have printed in the RECORD the letter from William E. Moschella, Assistant Attorney General.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. DEPARTMENT OF JUSTICE, OFFICE OF LEGISLATIVE AFFAIRS, OFFICE OF THE ASSISTANT ATTORNEY GENERAL.

Washington, DC, June 17, 2003.

Hon. W.J. (BILLY) TAUZIN,
Chairman, Committee on Energy and Commerce, U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: This is to advise you of the Department's support for a provision in the Medicare Prescription Drug and Modernization Act, set forth in Title III, Section 301, which would protect the integrity of the Medicare Trust Fund by clarifying that Medicare must be reimbursed whenever another insurer's responsibility to pay has been established. The Section is consistent with the litigation positions taken by this Department and the Department of Health and Human Services (''HHS'') in numerous court cases.

Congress enacted the Medicare Secondary Payer (''MSP'') statute in 1980 to protect the fiscal integrity of the Medicare program by making Medicare a secondary, rather than a primary, payer of health benefits. To ensure that Medicare would be secondary, Congress precluded it from making payment when a primary plan has already made payment or can reasonably be expected to pay promptly. Congress recognized, however, that in contested cases, payments under such plans would be delayed. To protect providers, suppliers, and beneficiaries, Congress authorized Medicare to make a ''conditional'' payment when prompt resolution of a claim cannot reasonably be expected. The Medicare Trust Fund must be reimbursed, however, once the primary insurer's obligation to pay is demonstrated.

Some recent court decisions have held, however, that Medicare has no right to reimbursement unless the primary insurer could reasonably have been expected to make prompt payment at the outset. *See, e.g., Thompson v. Goetzmann*, 315 F.3d 457 (5th Cir. 2002). These rulings make the statute's reimbursement mechanism inoperative in some jurisdictions. Section 301 of this legislation would end this costly litigation and provide clear legislative guidance regarding Medicare's status as a secondary payer of health benefits. The technical changes in Section 301 make clear that Medicare may make a conditional payment when the primary plan has not made or is not reasonably expected to make prompt payment.

The technical amendments of Section 301 clarify other provisions of the MSP statute, as well. They make clear that a primary plan may not extinguish its obligations under the MSP statute by paying the wrong party (i.e., by paying the Medicare beneficiary or the provider instead of reimbursing the Medicare Trust Fund. The Section clarifies that a primary plan's responsibility to make payment with respect to the same item or service paid for by Medicare may be demonstrated, among other ways, by a judgment, or a payment conditioned upon the recipient's compromise, waiver or release of items or services included in the claim against the primary plan or its insurer; no finding or admission of liability is required. In addition, Section 301 makes clear that an entity will be deemed to have a ''self-insured plan'' if it carries its own risk, in whole or in part. Finally, the Section makes clear that the Medicare program may seek reimbursement from a primary plan, from any or all of the entities responsible for or required to make payment under a primary plan, and additionally from any entity that has received payment from the proceeds of a primary plan's payment. These provisions of Section 301 will resolve contentious litigation and are designed to protect the fiscal integrity of the Medicare program.

We hope that this information is helpful. The Office of Management and Budget has advised that there is no objection to this report from the standpoint of the Administration's program. Please let us know if we may be of additional assistance.

Sincerely,

WILLIAM E. MOSCHELLA,
Assistant Attorney General.

Mr. HARKIN. So again, we have an amendment that is exactly what the President had in his 2004 budget request. We have an offset supported also by the administration. So this is truly a bipartisan effort.

This amendment Senator SMITH and I have offered is widely supported by older Americans and people with disabilities. AARP, the Consortium of Citizens with Disabilities, ADAPT, the National Council on Independent Living, the National Council on the Aging, and the National Association of Area Agencies on Aging all support this amendment.

Both parts of this amendment—the Money Follows Program and the offsets—are about fairness and justice. If this amendment is adopted, private insurers will pay their fair share of Medicare costs and people with disabilities will have the opportunity to live in their own communities.

I will just talk about a constituent of mine, Ken Kendall. Ken was injured in an accident and has a serious spinal cord injury. When he lost his health insurance, he was forced to go on Medicaid, and his only choice was a nursing home almost 2 hours from his friends and family.

Ken recently wrote to me that he went to dinner and a movie for his 30th birthday. No big deal, except he had not been to dinner and a movie in the 2 years since he went into a nursing home. He said: ''I was almost in tears. I felt like I had a real life again.''

This amendment would give people like Ken a real life again, and not just on their birthdays. Individuals with

disabilities should not have to continue waiting to enjoy the opportunities all other Americans take for granted.

So again, that is the essence of the amendment.

AMENDMENT NO. 991, AS MODIFIED

Mr. President, I ask unanimous consent that the amendment be modified with the modification I send to the desk. This is a modification to amendment No. 991.

The PRESIDING OFFICER. Is there objection?

Without objection, the amendment is so modified.

The amendment (No. 991), as modified, is as follows:

At the appropriate place, insert the following:

TITLE ___—MEDICAID DEMONSTRATION PROJECTS

SEC. ___01. SHORT TITLE.

This title may be cited as the ''Money Follows the Person Act of 2003''.

SEC. ___02. FINDINGS.

Congress makes the following findings:

(1) In his budget for fiscal year 2004, President George W. Bush proposes a ''Money Follows the Person'' rebalancing initiative under the medicaid program to help States rebalance their long-term services support systems more evenly between institutional and community-based services.

(2) The President, by proposing this initiative, and Congress, recognize that States have not fully developed the systems needed to create a more equitable balance between institutional and community-based services spending under the medicaid program.

(3) While a few States have been successful at achieving this balance, nationally, approximately 70 percent of the medicaid funding spent for long-term services is devoted to nursing facilities and intermediate care facilities for the mentally retarded. Only 30 percent of such funding is spent for community-based services.

(4) As a result, there are often long waiting lists for community-based services and supports.

(5) In the Americans with Disabilities Act of 1990, Congress found that individuals with disabilities continue to encounter various forms of discrimination, including segregation, and that discrimination persists in such critical areas as institutionalization.

(6) In 1999, the Supreme Court held in *Olmstead v. LC* (527 U.S. 581 (1999)) that needless institutionalization is discrimination under the Americans with Disabilities Act of 1990, noting that institutional placement of people who can be served in the community ''perpetuates unwarranted assumptions that persons so isolated are unworthy of participating in community life.'' (Id. at 600). The Court further found that ''confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.'' (Id. at 601).

(7) Additional resources would be helpful for assisting States in rebalancing their long-term services support system and complying with the *Olmstead* decision.

SEC. ___03. AUTHORITY TO CONDUCT MEDICAID DEMONSTRATION PROJECTS.

(a) DEFINITIONS.—In this section:

(1) COMMUNITY-BASED SERVICES AND SUPPORTS.—The term ''community-based services and supports'' means, with respect to a State, any items or services that are an allowable expenditure for medical assistance under the State medicaid program, or under a waiver of such program and that the State determines would allow an individual to live in the community.

(2) INDIVIDUAL'S REPRESENTATIVE; REPRESENTATIVE.—The terms ''individual's representative'' and ''representative'' mean a parent, family member, guardian, advocate, or authorized representative of an individual.

(3) MEDICAID LONG-TERM CARE FACILITY.—The term ''medicaid long-term care facility'' means a hospital, nursing facility, or intermediate care facility for the mentally retarded, as such terms are defined for purposes of the medicaid program.

(4) MEDICAID PROGRAM.—The term ''medicaid program'' means the State medical assistance program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(6) STATE.—The term ''State'' has the meaning given such term for purposes of the medicaid program.

(b) STATE APPLICATION.—A State may apply to the Secretary for approval to conduct a demonstration project under which the State shall provide community-based services and supports to individuals—

(1) who are eligible for medical assistance under the medicaid program;

(2) who are residing in a medicaid long-term care facility and who have resided in such facility for at least 90 days; and

(3) with respect to whom there has been a determination that but for the provision of community-based services and supports, the individuals would continue to require the level of care provided in a medicaid long-term care facility.

(c) REQUIREMENTS.—A State is not eligible to conduct a demonstration project under this section unless the State certifies the following:

(1) With respect to any individual provided community-based services and supports under the demonstration project, the State shall continue to provide community-based services and supports to the individual under the medicaid program (and at the State's Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act) reimbursement rate), for as long as the individual remains eligible for medical assistance under the State medicaid program and continues to require such services and supports, beginning with the month that begins after the 12-month period in which the individual is provided such services and supports under the demonstration project.

(2) The State shall allow an individual participating in the demonstration project (or, as appropriate, the individual's representative) to choose the setting in which the individual desires to receives the community-based services and supports provided under the project.

(3) The State shall identify and educate individuals residing in a medicaid long-term care facility who are eligible to participate in the demonstration project (and, as appropriate the individual's representative) about the opportunity for the individual to receive community-based services and supports under the demonstration project.

(4) The State shall ensure that each individual identified in accordance with paragraph (3) (and, as appropriate, the individual's representative), has the opportunity, information, and tools to make an informed choice regarding whether to transition to the community through participation in the demonstration project or to remain in the medicaid long-term care facility.

(5) The State shall maintain an adequate quality improvement system so that individuals participating in the demonstration project receive adequate services and supports.

(6) The State shall conduct a process for public participation in the design and development of the demonstration project and such process shall include the participation of individuals with disabilities, elderly individuals, or individuals with chronic conditions who are part of the target populations to be served by the demonstration project, and the representatives of such individuals.

(7) The Federal funds paid to a State pursuant to this section shall only supplement, and shall not supplant, the level of State funds expended for providing community-based services and supports for individuals under the State medicaid program as of the date the State application to conduct a demonstration project under this section is approved.

(d) APPROVAL OF DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall conduct a competitive application process with respect to applications submitted under subsection (b) (taking into consideration the preferences provided under paragraph (2)) that meet the requirements of subsection (c). In determining whether to approve such an application, the Secretary may waive the requirement of—

(A) section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) to allow for sub-State demonstrations;

(B) section 1902(a)(10)(B) of such Act (42 U.S.C. 1396a(a)(10)(B)) with respect to comparability; and

(C) section 1902(a)(10)(C)(i)(III) of such Act (42 U.S.C. 1396a(a)(10)(C)(i)(III)) with respect to income and resource limitations.

(2) PREFERENCE FOR CERTAIN APPLICATIONS.—In approving applications to conduct demonstration projects under this section, the Secretary shall give preference to approving applications that indicate that the State shall do the following:

(A) Design and implement enduring improvements in community-based long-term services support systems within the State to enable individuals with disabilities to live and participate in community life, particularly with respect to those practices that will ensure the successful transition of such individuals from medicaid long-term care facilities into the community.

(B) Design and implement a long-term services support system in the State that prevents individuals from entering medicaid long-term care facilities in order to gain access to community-based services and supports.

(C) Engage in systemic reform activities within the State to rebalance expenditures for long-term services under the State medicaid program through administrative actions that reduce reliance on institutional forms of service and build up more community capacity.

(D) Address the needs of populations that have been underserved with respect to the availability of community services or involve individuals or entities that have not previously participated in the efforts of the State to increase access to community-based services.

(E) Actively engage in collaboration between public housing agencies, the State medicaid agency, independent living centers, and other agencies and entities in order to coordinate strategies for obtaining community integrated housing and supportive services for an individual who participates in the demonstration project, both with respect to

the period during which such individual participates in the project and after the individual's participation in the project concludes, in order to enable the individual to continue to reside in the community.

(F) Develop and implement policies and procedures that allow the State medicaid agency to administratively transfer or integrate funds from the State budget accounts that are obligated for expenditures for medicaid long-term care facilities to other accounts for obligation for the provision of community-based services and supports (including accounts related to the provision of such services under a waiver approved under section 1915 of the Social Security Act (42 U.S.C. 1396n)) when an individual transitions from residing in such a facility to residing in the community.

(e) PAYMENTS TO STATES.—

(1) IN GENERAL.—The Secretary shall pay to each State with a demonstration project approved under this section an amount for each quarter occurring during the period described in paragraph (2) equal to 100 percent of the State's expenditures in the quarter for providing community-based services and supports to individuals participating in the demonstration project.

(2) PERIOD DESCRIBED.—The period described in this paragraph is the 12-month period that begins on the date on which an individual first receives community-based services and supports under the demonstration project in a setting that is not a medicaid long-term care facility and is selected by the individual.

(f) REPORTS.—

(1) IN GENERAL.—Each State conducting a demonstration project under this section shall submit a report to the Secretary that, in addition to such other requirements as the Secretary may require, includes information regarding—

(A) the types of community-based services and supports provided under the demonstration project;

(B) the number of individuals served under the project;

(C) the expenditures for, and savings resulting from, conducting the project; and

(D) to the extent applicable, the changes in State's long-term services system developed in accordance with the provisions of subsection (d)(2).

(2) UNIFORM DATA FORMAT.—In requiring information under this subsection, the Secretary shall develop a uniform data format to be used by States in the collection and submission of data in the State report required under paragraph (1).

(g) EVALUATIONS.—The Secretary shall use an amount, not to exceed one-half of 1 percent of the amount appropriated under subsection (h) for each fiscal year, to provide, directly or through contract—

(1) for the evaluation of the demonstration projects conducted under this section;

(2) technical assistance to States concerning the development or implementation of such projects; and

(3) for the collection of the data described in subsection (f)(1).

(h) FUNDING.—

(1) IN GENERAL.—There is appropriated to carry out this section—

(A) $300,000,000 for fiscal year 2004; and

(B) $350,000,000 for each of fiscal years 2005 through 2008.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) for a fiscal year shall remain available until expended, but not later than September 30, 2008.

SEC. ___04. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

Mr. HARKIN. Mr. President, all this modification does is it changes the first year, but it leaves everything else the same. This was $350 million each of the 5 years. This is now $300 million in the first year, and $350 million for each of the 4 years thereafter.

So again, as I said, 13 years ago we passed the Americans with Disabilities Act. We said no to segregation of people with disabilities. Ever since that time, Medicaid still continues to segregate people. When 70 percent of their money goes for institutional care, and only 30 percent goes for community-based care, it is time to break that down and give people with disabilities the right to exercise their own choice about where they want to live. And that, really, is the essence of the amendment.

I hope Senators will support the amendment overwhelmingly since, as I said, it was in the President's 2004 budget and the offset we have used is also fully supported by the administration.

With that, Mr. President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. I ask unanimous consent to set the pending amendment aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1087

(Purpose: To permit the offering to consumer-driven health plans under MedicareAdvantage)

Mr. GRASSLEY. I rise to offer an amendment for Senator CRAIG. I send the amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY], for Mr. CRAIG, proposes an amendment numbered 1087.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. GRASSLEY. I am doing this for Senator CRAIG. I am going to yield the floor because Senator CRAIG is going to discuss his amendment tomorrow.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BAUCUS. I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 992 WITHDRAWN

Mr. BAUCUS. On behalf of the Senator from Michigan, Ms. STABENOW, I ask unanimous consent amendment No. 992 be withdrawn.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENTS NOS. 941, 961, 983 EN BLOC

Mr. GRASSLEY. Mr. President, I call up amendments Nos. 941, 961, and 983 en bloc.

The PRESIDING OFFICER. The clerk will report the amendments.

The legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY], for Mr. WYDEN, proposes an amendment numbered 941.

The Senator from Iowa [Mr. GRASSLEY], for Mrs. MURRAY, proposes an amendment numbered 961.

The Senator from Iowa [Mr. GRASSLEY], for Mr. SPECTER, proposes an amendment numbered 983.

The amendments are as follows:

AMENDMENT NO. 941

(Purpose: To provide for a study by MedPAC on Medicare payments and efficiencies in the health care system)

At the end of title IV, add the following:

SEC. ___. MEDPAC STUDY ON MEDICARE PAYMENTS AND EFFICIENCIES IN THE HEALTH CARE SYSTEM.

Not later than 18 months after the date of enactment of this Act, the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) shall provide Congress with recommendations to recognize and reward, within payment methodologies for physicians and hospitals established under the medicare program under title XVIII of the Social Security Act, efficiencies, and the lower utilization of services created by the practice of medicine in historically efficient and low-cost areas. Measures of efficiency recognized in accordance with the preceding sentence shall include—

(1) shorter hospital stays than the national average;

(2) fewer physician visits than the national average;

(3) fewer laboratory tests than the national average;

(4) a greater utilization of hospice services than the national average; and

(5) the efficacy of disease management and preventive health services.

AMENDMENT NO. 961

(Purpose: To fund the blended capitation rate for purposes of determining benchmarks under the MedicareAdvantage program)

At the end of subtitle A of title II, add the following:

SEC. ___. IMPROVEMENTS IN MEDICAREADVANTAGE BENCHMARK DETERMINATIONS.

(a) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)), as amended by section 203, is amended by inserting ''who are enrolled in a MedicareAdvantage plan'' after ''the average number of medicare beneficiaries''.

(b) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w–23(c)), as amended by section 203, is amended—

(1) in paragraph (1)(A)—

(A) in clause (ii), by striking the comma at the end and inserting a period; and

(B) by striking the flush matter following clause (ii); and

(2) by striking paragraph (5).

(c) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICARE+CHOICE PAYMENT RATES.—

(1) FOR PURPOSES OF CALCULATING MEDICARE+CHOICE PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (E)''; and

(B) by adding at the end the following new subparagraph:

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(2) FOR PURPOSES OF CALCULATING LOCAL FEE-FOR-SERVICE RATES.—Section 1853(d)(5) (42 U.S.C. 1395w–23(d)(5)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''; and

(B) by adding at the end the following new subparagraph:

''(C) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the local fee-for-service rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on and after January 1, 2006.

AMENDMENT NO. 983

(Purpose: To provide medicare beneficiaries with information on advance directives)

On page 676, after line 22, insert the following:

SEC. ___. PROVISION OF INFORMATION ON ADVANCE DIRECTIVES.

Section 1804(c) of the Social Security Act (42 U.S.C. 1395b–2(c)) is amended—

(1) by redesignating paragraphs (1) through (4) as subparagraphs (A) through (D), respectively;

(2) in the matter preceding subparagraph (A), as so redesignated, by striking ''The notice'' and inserting ''(1) The notice''; and

(3) by adding at the end the following:

''(2)(A) The Secretary shall annually provide each medicare beneficiary with information concerning advance directives. Such information shall be provided by the Secretary as part of the Medicare and You handbook that is provided to each such beneficiary. Such handbook shall include a separate section on advanced directives and specific details on living wills and the durable power of attorney for health care. The Secretary shall ensure that the introductory letter that accompanies such handbook contain a statement concerning the inclusion of such information.

''(B) In this section:

''(i) The term 'advance directive' has the meaning given such term in section 1866(f)(3).

''(ii) The term 'medicare beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A or enrolled under part B, of this title.''.

AMENDMENTS NOS. 941, 967, AS MODIFIED; 961, 974, 983, AND 1010, EN BLOC

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the following amendments be agreed to en bloc and the motion to reconsider be laid upon the table en bloc: Amendments Nos. 941, 967, as modified; 961, 974, 983, and 1010.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendments (Nos. 941, 961, 974, 983, and 1010) were agreed to.

The amendment (No. 967), as modified, was agreed to as follows:

(Purpose: To provide improved payment for certain mammography services)

At the end of subtitle B of title IV, add the following:

SEC. ___. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 13951(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: ''and does not include screening mammography (as defined in section 1861(jj)) and unilateral and bilateral diagnostic mammography''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to mammography performed on or after January 1, 2015.

The PRESIDING OFFICER. The Senator from Montana.

AMENDMENTS NOS. 1088, 1089, 1090, AND 1091, EN BLOC

Mr. BAUCUS. Mr. President, on behalf of Senator MIKULSKI, I send four amendments to the desk and ask unanimous consent that the pending amendments be set aside so that the amendments might be offered. I don't know whether it is permissible to get consent to offer all four or we have to do it individually?

I send to the desk the four amendments en bloc and ask that the pending amendments be set aside. The amendments, for the purposes of consent, are to provide equal or equitable treatment for children's hospitals. Another is on the same subject. The third is to permit direct payment under the Medicare Program for clinical social worker

services provided to residents of skilled nursing facilities. And the fourth is to extend certain municipal health service demonstration projects.

The PRESIDING OFFICER. Without objection, the clerk will report the amendments by number.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Ms. MIKULSKI, proposes amendments Nos. 1088 through 1091 en bloc.

The amendments are as follows:

AMENDMENT NO. 1088

(Purpose: To provide equitable treatment for children's hospitals)

At the end of subtitle B of title IV, add the following:

SEC. ___. EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 13951(t)(7)(D)(ii)) is amended to read as follows:

''(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

''(I) CANCER HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(v), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

''(II) CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii), for covered OPD services furnished before October 1, 2003, and for which the PPS amount is less than the pre-BBA amount the amount of payment under this subsection shall be increased by the amount of such difference. In the case of such a hospital, for such services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions incurred in furnishing such services, the amount of payment under this subsection shall be increased by the amount of such difference.''.

AMENDMENT NO. 1089

(Purpose: To provide equitable treatment for certain children's hospitals)

At the end of subtitle B of title IV, add the following:

SEC. ___. EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 13951(t)(7)(D)(ii)) is amended to read as follows:

''(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

''(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

''(II) SPECIAL RULE FOR CERTAIN CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii) that is located in a State with a reimbursement system under section 1814(b)(3), but that is not reimbursed under such system, for covered OPD services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions of the hospital in providing such services, the amount of payment under this subsection shall be increased by the amount of such difference.''.

AMENDMENT NO. 1090

(Purpose: To permit direct payment under the medicare program for clinical social worker services provided to residents of skilled nursing facilities)

At the end of subtitle A of title IV, add the following:

SEC. ___. PERMITTING DIRECT PAYMENT UNDER THE MEDICARE PROGRAM FOR CLINICAL SOCIAL WORKER SERVICES PROVIDED TO RESIDENTS OF SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting ''clinical social worker services,'' after ''qualified psychologist services,''.

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) (42 U.S.C. 1395x(hh)(2)) is amended by striking ''and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2003.jennifer

AMENDMENT NO. 1091

(Purpose: To extend certain municipal health service demonstration projects)

At the end of title VI, add the following:

SEC. ___. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as previously amended, is amended by striking ''December 31, 2004, but only with respect to'' and all that follows and inserting ''December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated and so long as the total number of individuals participating in the project does not exceed the number of such individuals participating as of January 1, 1996.''.

Mr. BAUCUS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that at 9:15 tomorrow morning, the Senate proceed to a vote in relation to Harkin amendment No. 991, to be followed by a vote in relationship to the Edwards amendment No. 1052; provided further that there be 2 minutes equally divided before each vote and that no second-degree amendments be in order to the amendments prior to the vote.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. COLEMAN). Without objection, it is so ordered.

AMENDMENT NO. 1092

(Purpose: To evaluate alternative payment and delivery systems)

Mr. GRASSLEY. Mr. President, I send an amendment to the desk for myself and Senator BAUCUS and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY], for himself and Mr. BAUCUS, proposes an amendment numbered 1092.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The amendment is printed in Today's RECORD under ''Text of Amendments.'')

Mr. GRASSLEY. This is an amendment I have worked out with Senator BAUCUS after considerable consultation with many colleagues on both sides of the aisle. The amendment has two parts. First, it would permit the Secretary, starting in 2009, to designate an alternative payment system for PPOs in a limited number of regions that the Secretary has determined to be highly competitive. This alternate payment system would permit the Secretary to set the Federal contribution for participation plans solely based on the bids they submit to the Secretary. The Secretary would still be required to choose the three plans with the lowest credible bids to participate. The Federal contribution would be set for the three plans participating by the second lowest bid submitted.

The second thing the amendment would do is authorize the Secretary, also starting in 2009, to establish a number of projects in the fee-for-service Medicare Program. These projects would be designed to provide enhanced services or benefits to improve the quality of care provided to Medicare beneficiaries, to improve the health care delivery system under the Medicare Program, and lower expenditures in that program. The enhanced services or benefits would include preventive services, chronic care coordination, disease management services, or other services the Secretary determines will advance the purposes of these projects.

The total cost of this amendment would be $12 billion starting in the year 2009 and would be equally divided between the alternative payment system and the fee-for-service projects.

Mr. President, this amendment represents a very reasonable compromise on the question of how to introduce into the Medicare Advantage Program a more competitive payment system.

I thank everyone, and most especially Senator BAUCUS, for working so hard and in a cooperative spirit to develop this amendment now before the Senate.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, first, I thank my good friend and colleague, the chairman of the committee, Senator GRASSLEY, for his Job-like patience, as we have worked extremely hard with various Senators to try to come up with—and I think we have—a compromise, balanced solution as to how we spend the newly discovered $12 billion.

I have a couple of points. The intent of this amendment and the language of this amendment accomplish a couple of purposes: No. 1, to evenly divide the $12 billion—$6 billion and $6 billion—to be available to be potentially used by PPOs in areas designated by the Secretary, and the other $6 billion to be spent in additional Medicare Programs for disease management, chronic care, and other ways to help particularly address the lack of coordination services for the chronically ill and those seniors who particularly need disease management.

The amendment also has a couple other provisions, and to maintain the balance, maintain the symmetry is so important. I will remind my colleagues that in an attempt to get prescription drug benefits to seniors—something we all want to do—we are faced with two competing ideas. One is competition and the other is traditional Medicare. So the underlying bill is an attempt to work those two concepts together. This amendment follows on that tradition. It follows the same spirit, the same symmetry.

I mentioned the $6 billion and $6 billion. In addition, the amendment provides the authority to continue in the applicable number of years—beginning in 2009 through 2013—and the $12 billion is not available until then anyway. That is the problem we have. It doesn't start until 2009. But it is $6 billion available for potential PPO use and $6 billion for disease management, starting in 2009, for a 5-year period. In addition, the authority for both under this amendment continues into the future beyond the 5-year period.

In addition, the language is written so it is an absolutely clear, ironclad guarantee that after the 5-year period no further dollars will be spent on either side, either the $6 billion available for PPOs or the $6 billion to be available for disease management, et cetera. It is very important to maintain that symmetry and balance in order to accomplish the spirit of cooperation so that we get this program started, get the prescription drug program that we want delivered and on its way.

This is not perfect, but I can tell you that many hours have been devoted by many Senators on both sides of the aisle to come up with this solution, which does achieve that balance.

I urge Senators to support this. This is going to break the logjam. This is the key amendment which has been topic A. Many Senators are wondering about this as they are thinking about other amendments they may or may not offer.

I hope with the passage of this amendment we will be able to take up other amendments Senators have tomorrow and debate them and finally, hopefully, by sometime tomorrow and Thursday—perhaps at a late time on Thursday—pass this legislation and send it to conference.

I yield the floor.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. FRIST. Mr. President, I rise to speak in support of this amendment, which is a product of about 48 hours of discussion and negotiation, in terms of packaging. I really speak in support of both of the parts of this amendment to which the managers have just spoken.

In the next couple days—hopefully maybe tomorrow night or the next morning—we will indeed have a historic vote to provide America's seniors with coverage they simply don't have today, don't have access to today—prescription drugs, preventive care, and chronic disease management. That is in the underlying bill.

Seniors will have the opportunity, for the first time, to choose the sort of coverage that best suits their individual needs. At the same time, they will have access to a benefit they don't have today, and that is in the underlying bill.

I support the amendment just introduced because it makes the bill even better for two reasons. No. 1—and this is where about $6 billion is spent—it strengthens the competitive model.

Ultimately, I believe—and I think the majority of people in this body believe—the only way we are going to be able to increase quality over the long term, in 10, 20, or 30 years, at the same time we have this unprecedented increase in the number of seniors in this country, a doubling in the number of seniors over the next 30 years, is to take advantage of the dynamism of the private sector where we can obtain the efficiencies that a command-and-control type plan, a Government-type plan simply cannot capture. It is the only way. Half of this amendment concentrates just on that—about $6 billion—to make those competitive, private sector dynamic, marketplace principles, yes, regulated by Government, work.

The other half of the amendment, the other $6 billion, also does something which we stress in the underlying bill, but through this amendment we will spend an additional $6 billion in supporting and investing in what we call preventive medicine, chronic disease management, coordinated chronic disease management we know how to address, but we have insufficiently invested in to maximize the care, the health care security our seniors deserve.

I will refer to a couple charts to explain why I am so excited about both aspects of this bill. I will first take the half of the bill that has to do with chronic disease management, and it links with what I prefaced in my remarks; that is, doubling the number of seniors. The challenge is going to be to sustain this long term; that is, Medicare long term.

If we look at overall numbers of beneficiaries in Medicare today, we know there are about 40 million beneficiaries, and this chart shows the percentage of beneficiaries. As we look at the total amount of moneys being spent today by those beneficiaries, those patients, those seniors, those individuals with disabilities who are a part of Medicare, we find that 6 percent, or about 1 in 20, account for 50 percent of all the money that is expended in Medicare today.

Since we know that health care is expensive, what we need to do, I believe, to make sure we get the best value for each health care dollar, each tax dollar that is paid to Government or that is paid for by the beneficiary, is to make sure this money is spent effectively and efficiently.

How do we do that? We ought to spend a lot of time focusing on this 50 percent, which is really 1 out of every 20 people. So in this body of 100 people, there would be six—just these six desks around me—accounting for 50 percent of all the expenditures. So why don't we figure out why these six people are so expensive?

Who are these six people? In this next chart, I will show you who they are because once we identify them and give them the very best coordinated care possible, I believe that number will reduce over time.

On this next chart, these ''CCs'' stand for chronic conditions. By ''chronic condition,'' I mean heart failure, diabetes, chronic obstructive pulmonary disease, or emphysema.

What we find if we look at all Medicare expenditures—say this pie chart is all the money we spend on Medicare—most of the expenses are on individuals who have five chronic care conditions, and then those who have four chronic care conditions is about 13 percent; three chronic care conditions about 10 percent; two chronic conditions, say heart failure and diabetes, 7 percent.

By concentrating on people with chronic conditions, and if we give them coordinated care, seamless care, if we give them prescription drugs, which this bill does for the first time, if we help them with maybe a nurse calling once a week to help manage their care, use resources appropriately, over the long haul, this program will be sustainable.

I walked through these two charts because all of us know that Medicare is expensive, and we know that over time we need to fund whatever program we do, so let's concentrate our policy on where the expenses are, these six individuals, if we use this body as an example, and those are the people who have chronic care conditions.

Thus, this amendment, $6 billion of $12 billion, is being spent, focused like a laser beam on people with chronic care conditions. That is what the amendment does.

The underlying bill does that by setting up these PPOs, Medicare Advantage and Medicare+Choice, which gives seamless coordinated care built in a competitive marketplace. The underlying bill does that, but what this amendment does is focus an additional $6 billion on people with chronic conditions.

Also, part of that money is to improve preventive care, and we all know it is a lot cheaper to figure out who is going to get sick from heart disease and treat them accordingly than waiting until they get sick and are hospitalized and they develop what is called end stage cardiomyopathy. To me it is exciting.

I mentioned diabetes because diabetes is one of the conditions that I think best demonstrates how modern medicine today can, if properly managed, both have better outcome and lower cost. Today there are about 17 million Americans who suffer from diabetes. Another 16 million adults are at risk for developing the condition, and over the past decade, the number of diagnosed cases of diabetes has risen sharply.

Just in the last several weeks, the American-Diabetes-Association-sponsored study indicated that one-third, one out of every three children born in the United States this year will develop diabetes in their lifetime—one out of every three. So if you are a parent and listening to me now, and you have three children, one of those statistically will develop diabetes over their lifetime. It is huge. The National Health Interview Survey projects that 45 to 50 million Americans will have diabetes by 2050.

If we ineffectively manage diabetes, if we do not have access to the latest drugs, the appropriate management, the cost of managing and treating diabetes is huge. According to the American Diabetes Association, $91.9 billion was spent last year just in direct medical expenses for diabetics. Today, more than $1 in every $7 spent on health care in the United States is spent on behalf of diabetic patients.

I mention all of this because we know that health care costs for diabetes, if not managed in a coordinated system, are huge, and based on the statistics I just said with this dramatic increase in diabetes will increase over time.

How do we address it? We address it through an integrated health care model where you look at diet, you look at exercise, you look at drugs, you look at the appropriate testing to monitor blood sugars, and you have coordinated care. That is what we do in this Medicare PPO, Medicare Advantage model, and diabetes would fall into one of these chronic conditions. And we are going to be investing another $6 billion through this amendment in the overall management of conditions like diabetes.

The other—and I will close in a minute or so—the other $6 billion of this amendment, the other half of this amendment, is invested in increasing the competitive model.

I commented on this briefly, but what this allows us to do is to take advantage of what we know is in the marketplace today. We know that command and control and price controls run out of Washington, DC, do not work. We have tried it. We have seen it in Medicare in the past, and it resulted in a system that, yes, has been good for seniors, but it has not stayed abreast with the great advances we have seen in health care delivery or the new technology today. So we need a more responsive system, one that takes advantage of new innovation, new technology in the marketplace, that captures those dynamics of market-based competition. It is the private sector working in partnership with the public sector.

I will close by saying that I feel strongly that this amendment will incrementally, greatly improve health care for our seniors today. It will be debated, I am sure, over the course of the evening tonight and early in the morning. It is a product of a lot of working together, Democrats and Republicans, over the last 48 hours to put together the very best ideas for improving competition and market-based fundamentals and, at the same time, focusing on preventive medicine, prevention of disease, management of those chronic conditions, where many of the challenges exist in Medicare today.

We are nearing a historic vote to provide America's current and future seniors comprehensive health care coverage. Friday, we will pass legislation to improve and strengthen Medicare. The transformed program will offer modern and innovative coverage for procedures ranging from physical exams to hospital visits. And most significantly, the updated Medicare system will, for the first time, offer seniors prescription drug coverage. As a doctor who has served thousands of Medicare patients, I am committed to ensuring health care security for our seniors. Prescription drugs must be a part of that security.

The bipartisan bill offers seniors more choice and flexibility. Seniors will be able to stay with traditional Medicare, or they will have the option of being covered under Medicare Advantage. Medicare Advantage will offer better benefits and up-to-date medical care, including: preventive care; disease management; and protection from catastrophic costs. It will also, of course, offer comprehensive prescription drug coverage.

Seniors all across the country, including in rural areas, will have a Medicare plan that offers them similar types of benefits 8 million current and retired Federal employees now enjoy. Medicare Advantage is designed to combine the best of the Government and private sector and provide security, choice, quality, safety, flexibility and innovation. Chronic health problems especially will be tackled with more resources and better results.

The amendment will significantly strengthen the bill in this regard. Most importantly, it allows the Secretary of Health and Human Services additional flexibility to institute a true competitive bidding model for PPOs and other Medicare Advantage coordinated health plans. It does this by allowing payments to plans without regard to a benchmark linked to current payments under the Medicare+Choice or Medicare FFS system.

The second part of the amendment will devote up to $6 billion additional funds, beginning in 2009, for the Secretary to conduct broad demonstration projects that will likely lead to improvements in the disease management, chronic care management, and preventive care provided to seniors who choose to remain in the traditional Medicare program. This is great progress for seniors. We are modernizing Medicare to keep pace with modern medicine and tackle chronic disease.

Diabetes is a good example of how modern medicine, through prescription drugs, is offering both therapeutic benefits today as part of an integrated care regimen and promises effective treatments and new types of health care delivery in the future.

Approximately 17 million Americans—6% of the population—now suffer from diabetes. Another 16 million adults are at risk for developing the condition. Over the past decade, the number of diagnosed cases of diabetes has risen sharply. A recent American Diabetes Association sponsored study indicated that one third of children born in the United States in the year 2000 will develop diabetes in their lifetimes. The National Health Interview Survey projects that 45 to 50 million Americans will have diabetic by 2050.

Undiagnosed and improperly treated, diabetes can cause a host of complications, including: kidney failure; heart disease; and loss of limb. Medical expenditures for persons with diabetes are four times as high as their non-diabetic counterparts, in large part, because of these complications. According to the American Diabetes Association, $91.9 billion dollars was spent last year just in direct medical expenses for diabetics. Today, more than one in every seven dollars spent on healthcare in the United States is spent on behalf of diabetic patients.

Indeed, the healthcare costs for diabetes threaten to add a significant financial burden to Medicare. But the good news is there is much we can do to prevent the illness. We know that patient education, weight control, exercise and treatment can significantly reduce the incidence of adult onset diabetes.

Meanwhile, since 1995, five new classes of medicine have been introduced to treat diabetes. These medicines, coupled with health management and coordinated care programs, are powerful tools to increase a patient's health status and reduce complications due to the illness.

For example, one comprehensive disease management program treated approximately 7,000 diabetic patients and produced savings of $50 to $100 per diabetic patient, per month. Pharmaceutical costs increased under the program, but total health care spending declined.

Why? Because of fewer emergency room visits, substantially fewer inpatient hospitalizations and reduced lengths of stay. At the same time, (HEDIS) measures of the quality of care these patients received significantly improved.

In other words, a modern, coordinated health approach to diabetes which included prescription drugs, led to reduced costs and improved outcomes. And diabetes is only one of many chronic conditions for which prescription drugs help clinicians optimize care and improve the quality of life for patients. This amendment will go far in advancing life saving prescription drug approaches.

This is an exciting week for the Senate and for the American people. We have built on years of research, discussion, and debate. We now have a bill that reflects broad bipartisan support. Thanks to the leadership of my colleagues in the Senate, and the commitment of President Bush, America's seniors will finally receive the health coverage they need and the security they deserve.

Medicine has come a long way since 1965. Now, so too, will Medicare.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Arizona.

AMENDMENT NO. 1093 TO AMENDMENT NO. 1092

(Purpose: To evaluate alternative payment and delivery systems)

Mr. KYL. Mr. President, I have an amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Arizona [Mr. KYL] proposes an amendment numbered 1093 to amendment No. 1092.

Mr. KYL. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. KYL. Mr. President, this is a second-degree amendment to the Baucus-Grassley amendment. I will explain it in just a moment, but while the majority leader is still in the Chamber, let me compliment him, not only for the fine presentation he just made based upon his personal knowledge of how the medical health care system in this country works but also for his leadership and the enormous amount of time and effort he has put into crafting this legislation and working with Members to try to resolve the many disputes that have arisen. I think without the patience he has shown in dealing with all of the Members, we would not be to this point that we are today, literally on the brink of passing, in the Senate, very historic legislation. So I compliment the majority leader and personally thank him for his patience in dealing with some of my concerns about the bill and the good work he has done in working with those problems.

I also want to thank Chairman GRASSLEY, who has shown a lot of patience and has worked hard in a very bipartisan way to put together a plan that could pass this body. I know that people on both sides of the aisle would prefer that it be closer to their particular points of view, but the chairman was always cognizant of the fact that in order to get a bill passed, it had to be done in a bipartisan way. So I compliment the chairman and ranking member for working in that fashion.

I also want to compliment and tell my colleagues a little bit about the efforts of the Secretary of HHS, Tommy Thompson. He, too, has become very personally involved in this effort and has worked very hard to effect the President's goals and plans in ensuring that we can strengthen, protect, improve and preserve Medicare. I appreciate his strong role as well.

I say all of that to make it clear that the amendment I offer is in the spirit of this bipartisan work, hopefully my work will be deemed to be cooperative with our leadership, although there is one element of the amendment Chairman GRASSLEY and Senator BAUCUS have laid down that I disagree with and this is what I am proposing to amend.

What I would like to do is explain the history of this and then come to my amendment. The amendment is very simple. It strikes a sunset provision, but that does not mean anything unless one knows the context, so let me speak for a moment about that context.

When the President first proposed this year that we legislate to add a new prescription drug benefit to Medicare, he said we should do it in the context of a real effort to strengthen Medicare so that we can preserve and protect it for the future. It has served our seniors well, but we are now in the 21st century and two things basically have occurred.

First, we now know that medicines, prescription drugs, are used as the preferred treatment for many illnesses and diseases, which was not the case back in 1965 when Medicare was first created. So all of us have become convinced that we need to add a prescription drug benefit to Medicare. This was the President's first great goal.

The second thing he said was, there is no way we can sustain the current promised benefits under Medicare if we do not create some new opportunities for Medicare beneficiaries, if we do not really strengthen the Medicare system we have. Among the things we can do to ensure that it will continue to work is to provide some choices for seniors, and so what he proposed was those people who would like to keep the existing Medicare, with a new prescription drug benefit, would be able to do that. But, especially for those younger seniors, people who have been in the workplace and are familiar with a PPO, or preferred provider, insurance plan or perhaps an HMO or Medicare+Choice kind of plan, we would provide that alternative as well so that the senior could choose. The idea was that a lot of the people that will be coming into the senior market, being used to an employer-provided plan, might like to keep that kind of plan rather than go into traditional Medicare. So we want to provide a choice, and it will be up to the senior to decide. So that is the direction that we sat down to work in as we developed this legislation.

I would have preferred that in creating this private market alternative, or the preferred provider organization—which we will hear referred to as PPOs—to the traditional Government Medicare system, we had made it much more like the FEHBP, the Federal Employees Health Benefits Program. That is a medical insurance plan that most of the people who are in this Chamber today have. It serves about 10 million Federal employees including family members and retirees. This is also the health plan for Members of Congress.

I would like to tell my seniors, if it is good enough for Members of Congress, then the seniors ought to take a look at it. It is a pretty good program. In fact, it is a very good program. I would have liked to have made this new Medicare Program alternative very much in the mold of the FEHBP, especially in the way that the preferred provider organizations work, bid, and are paid. We could have done that.

The way it works in the FEHBP is we do not have any limit on what kind of a bid the PPOs have to have. If they meet the basic criteria, providing the care we have mandated by statute, they can bid and provide the service and they can try to sell it to us. The federal government's share of the cost is determined by the use of a weighted average of all the health plans' costs.

If it is a good deal, federal employees and Members of Congress will sign up. If it is not a good deal, we will not. Generally, we do not tell the PPOs how much they can bid or how much they can charge. If they bid too much and charge too much, nobody is going to buy it. So they all have pretty reasonable bids and pretty reasonable costs, but theoretically they could bid themselves out of the market. It is up to them.

These insurance actuaries are pretty smart. They know how they can meet all of the requirements that they have. They have to be sure they cover the benefits they have promised. They have to provide those. They have to make a little profit, of course. They have to make sure the premiums are low enough so that people will sign up and, of course, most importantly in the beginning, they have to win the bid. If they do not win the bid, if they are so

high that nobody will sign up, well, then, there is no reason for them to be in the game in the first place.

They look at all of those things, and they figure out how much they can afford to bid, what the premiums will be, and so on. It is a pretty good plan, and I wish we could have been able to offer that to our seniors. But instead, the determination was made by Chairman GRASSLEY and others that we would take the key component of the President's plan with respect to the PPOs and write that up into the legislation, draft it up, and that section of the legislation says we are going to limit the number of bids because we really want to control the cost, and so we are going to say only the three lowest bids are going to succeed, and then the President proposed to pay the PPOs at the middle bid of the three bids.

So the insurance companies that bid have to figure out, how much is it going to cost us to provide care to each senior, and that is what they bid, but they have to be sure the bid is low enough that they win because only the three lowest ones will be accepted.

That is what President Bush proposed, and it is deemed to be a way of both providing a lower cost to the Government kind of care but a quality care because obviously people are not going to sign up and utilize it if they do not think it provides quality care.

There are a lot of things about the way PPOs operate that ensure good quality care. This is a good idea. The President proposed it, and that was the original idea in drafting this.

But then a very arbitrary thing happened. The people in this building know that everything we do has to be under the rules of the CBO, the Congressional Budget Office. Everything has to be scored by CBO. That is to say, we send it to CBO, and they tell us how much it is going to cost in their mind. When we said we were going to allocate $400 billion over 10 years to this new prescription drug benefit, we had to make sure that the CBO score fit within the $400 billion.

Well, CBO came along and they said this competitive bidding system was going to cost a lot more money—it was over a $100 billion—it was way more than Chairman GRASSLEY and Senator BAUCUS wanted to allocate to the preferred provider organization part of the system.

So they said, we have to do something that does not cost anything or does not cost very much. So they decided to solve the problem CBO had created by simply writing in, in effect, a limitation that said this will not cost anything because we are going to set it at the very same level as traditional Medicare payments. There is a complicated formula. I am not going to get into all the details, but essentially it is the higher of the Medicare+Choice payment rate or the traditional fee-for-service Medicare reimbursement level.

The bottom line is, they said we are going to cap the amount the PPOs could be reimbursed. If you want the contract, you can bid anything you want to bid, but you can't be reimbursed over a certain amount, and that amount is defined in statute. By definition, therefore, the score did not cost very much and therefore it could fit within this $400 billion. So they thought that might solve the problem.

But the problem with this is, it will not work. A lot of people realize it won't work, but we still have to comply with the CBO score, they say. I will get to a solution in a moment.

How do we know it won't work? CBO, the same organization that did the score, says all of 2 percent of seniors will sign up for this PPO alternative. Two percent. Why? Because this arbitrary capped rate is not going to be enough to provide the coverage for them that we promise. So why would they want to sign up with a PPO when they can get the coverage under traditional Medicare?

When I am eligible for Medicare, that is what I would do. I would not sign up if a plan cannot deliver the goods. CBO says only 2 percent will sign up. As a result, obviously, we have to find an alternative.

Let's go back to this question that CBO raised by its scoring and whether or not an arbitrary limit will actually work. CBO says it won't; only 2 percent are going to sign up.

Why do they say that? First, we have the experience of Medicare reimbursement over the last many, many years. Sadly, the government has a cap on what it pays the doctors and hospitals and other health care providers, too. We do that by statute. We say we are only going to pay you X amount if you do certain things and you cannot go above that.

What happens? After a while, there is so much upward pressure on that amount because it does not begin to keep track with inflation, especially health care inflation. Pretty soon the doctors are saying, we not only cannot make any money getting reimbursed at this low level, but we cannot pay our nurses, we cannot keep our doors open, there is no way we can stay in practice providing services to our senior citizens if you are going to pay this ridiculously low amount. In fact, a lot of doctors have retired, gotten out of the business, discouraged their kids from going into medicine, and we see real shortages, especially in certain specialties. There are other factors that lead to that as well, but this is a big one.

So every year or two, Congress, responding to that pressure, says: My goodness, we have to change that reimbursement level. It is too low. So then we have these big fits and starts where we hold it down for a while and then all of a sudden we raise it up to the level necessary to compensate the hospitals and the doctors and nurses to take care of our senior citizens. We did this for the physicians just a few months ago because they were getting cut significantly in the reimbursement rate and CBO said we paid $54 billion to fix the physician problem for basically one year. That is one-eighth of the amount of this entire bill, over a 10-year period, just to make sure that the cut did not go into effect last year for the doctors so they could stay in business.

We find there is supposed to be another cut in physician reimbursement levels this year, and again we are most likely going to have to make an adjustment.

The problem is artificial government controls, price controls, do not work. They do not work in Medicare any better than in rent control or the gasoline price controls we had in the 1970's or any other price controls. Free market countries like the United States have learned that lesson. Socialist countries have not. I would have thought we would have learned the lesson. But that is the way the Medicare system works. It is the perfect exhibit A if you want evidence of the fact these controls in providing health care services do not work. Just look at the reimbursement providers in Medicare today.

I mentioned it is a lot like rent control. There is always the inexorable pressure. Is it any wonder when you finally remove the rent controls that in some places the rents actually go up? The owners get enough to refurbish the place to keep it up and people are willing to rent the places that look a lot nicer and better than back when there were rent controls. Sometimes the prices do go up. That is the price of quality health care.

We should never get into the situation in this Congress where we are going to shortchange our seniors by trying to put artificial caps on what we pay the people who take care of them. It will not work.

There is no such thing as a free lunch. If you want quality health care, you are going to have to pay for it one way or another. It may work to have a price control for a little while, but it does not work for very long. We found that out, and that is why every couple of years we have to make the big adjustments.

So why would we think the price controls would work with the new preferred provider organizations that we are trying to establish as a credible alternative to traditional Medicare? A lot of people will find the benefits of those PPOs to their liking. Why do we think the price controls will allow them to work? CBO says it will not happen; only 2 percent will sign up. Clearly, we had to find a way out of this dilemma.

The bottom line is, under CBO's rationale, either nobody bids because they cannot get reimbursed or we have to do the constant adjustment. There is no adjustment provided for in this legislation. Or there is a modest adjustment, but not an adjustment that will take care of this problem.

What do we do to solve the problem? We do not want to create the PPO option and then destroy its effectiveness

before it can even work. I am very worried, to digress a moment, we will create some expectations on the part of our seniors that we cannot satisfy. That will be fundamentally wrong. It would be very wrong to suggest that we are going to do something for our seniors that, in fact, we are not doing. I, for one, am simply not going to be part of that. We cannot promise seniors an option that, in fact, we know, in advance will not work.

What is the solution? Obviously, the solution is to go back to the way we were going to do this in the first place, back to the President's proposal, and not have the arbitrary cap. Simply allow competitive bidding. Let the market decide what the right levels are. These people are smart. They will find the right level. It may be, in some areas, some time, below the Medicare reimbursement. That is what the Centers for Medicare and Medicaid Services, the organization that oversees these programs, believes. It may be the same. It may be more. It will be different from region to region and year to year. Let the market decide that.

Now, there was not enough money in the $400 billion to do this. So what happened was Chairman GRASSLEY and Senator BAUCUS were able to conclude that about $12 billion was available in the bill to be allocated for some purpose.

Very candidly, many Democrats did not want to do what I am suggesting. So they said you can only have half of the $12 billion to try to make your plan work. We want to use the other half to do something we want to do. What they want to do in the bill is perfectly reasonable, and I don't have any objection to the Grassley-Baucus amendment in that regard. In fact, I don't have any objection to most of the Grassley-Baucus amendment. I think it is a good amendment except for one thing.

What the amendment does for the $6 billion I spoke of, it says, starting in the year 2009, the Secretary of HHS can use competitive bidding that does not have this arbitrary payment cap on it, up to spending $6 billion if you have to spend it. The CBO scoring would suggest you could probably cover one or two of the 10 regions of the country if there were going to be 10 regions during one of the bidding cycles. It does not give us much of a chance to do this, but at least it establishes the principle.

The Secretary will at least have one chance, in one region, during one bidding period, to say at least in this situation we are going to eliminate our caps and see what happens.

Theoretically, if the bids come in below that cap, he still has the $6 billion to do that in another region. It is like somebody guaranteeing a loan. If the loans get paid off, then the person who guaranteed it never has to pay off. This is like $6 billion to guarantee the loan. This is $6 billion to see that the preferred provider organizations get paid, if in fact their bids exceed the Medicare cap level. It may exceed it; it may not.

Chances are, if it does not happen until 2009, which is the way the amendment is written, it will exceed it because of this pressure that inevitably builds when you have price controls keeping the prices down. So for 4 years the prices are going to be tamped down and finally then in the fifth year we get to go out to bids, and my guess is they probably will be higher and the proponents of the competitive bidding will say: See, we told you it would cost a lot of money. Of course. It might. If you tamp down something that the market would cause to rise a little bit every year and you tamp it down for 5 years and don't have some opportunity to adjust it, then naturally if you take the cap off it is going to rise. So CBO is probably correct, it probably will cost some money. That is the inevitable result of lifting the price control after you have kept things tamped down for too long.

The alternative, of course, is that there may not be any PPOs bidding because they cannot provide the services we have promised to seniors. But there is a little bit of an opportunity here to provide this unrestricted opportunity for bidding. That is what the amendment originally said that was drafted. I was originally going to be a cosponsor of the Grassley-Baucus amendment because even though it did not reestablish the competitive bidding process very much, there is a little sliver in there and at least we could go to conference, to the conference committee between the House and Senate, and argue that we had established the principle and we wanted to make sure that principle could continue on.

But, again, a funny thing happened. There were objections on the Democratic side to this process extending beyond the 5 years that it was in effect. What they said was you have to spend the $6 billion in that 5-year period. There will not be any money after that.

I said that's OK.

But then they said: And the authority to do this has to sunset at that moment, after 5 years. You cannot have the authority to do this, regardless of the cost, later on.

Later they said: Well, as long as it is cost neutral, but as I pointed out that is probably a false promise because of the price controls keeping the prices tamped down. So my amendment eliminates that sunset clause. It says: No, if this is a good idea, let it continue.

Ironically, if the CMS is correct, then it is not going to cost any more. And if CBO is correct, it is going to cost more and, as a result of that, we are going to have to have some alternative to the competitive bidding process with the price caps on it because there are not going to be any PPOs to offer the health care benefits. If, in fact, they cannot make it work under the money that is then available, there has to be an alternative available. That is why this should not sunset. It is why the authority to do this should continue on.

As to this point I just want to say I cannot imagine, after all the work that has gone into this—people have looked at how complex this is—we would think that we are smart enough in the Senate to know exactly what the price of this insurance contract ought to be for every Medicare beneficiary 10 years down the road. How do we know that? We cannot possibly know that. How do we know what a fair price for a Mercury automobile is going to be in 10 years? A price that is just exactly fair, that lets, say, Ford Motor Company make some money, just low enough to entice us to buy the car. We don't know that. That is why we have a free market. You charge whatever you want to charge and if it is a good deal, people will buy it; if it is not, they will not.

It is the same thing here. We are not smart enough to fix these prices and we are playing with the quality of health care of our senior citizens.

My fear is we are going to keep this ratcheted down so much that we will have an experience like we had not so long ago with the HMOs of this country, where they were squeezing the benefits and patients got pretty angry about it. They said, we don't want to have to go to a doctor we don't know, we don't want to have them tell us they can't see us for 6 weeks. We don't want them to say it would be nice to have a MRI or CAT scan but all we can give you is a X-ray. That is where the call for the Patients' Bill of Rights came in, and I supported it because I don't think patients should get squeezed down in their health care just because we are trying to save money.

Of course we want to save money. We are talking about taxpayer money here. But the whole concept of the preferred provider option, the private sector option, was to be able to save money in the long run for the Medicare system. That is why the President proposed it and why we, especially on the Republican side, said this is something we need to do to strengthen Medicare. We need to provide an option that will enable us to keep the costs of this under control as Medicare goes into the future. And for the reasons the majority leader articulated so well a moment ago, we believe these preferred provider organizations will be able to do that. So they can balance good quality care with efficiencies and effectiveness at cost control as well. That was the whole idea for it.

But we cannot get into a situation where we tie both hands behind their back and then tell them to go out and serve our senior citizens. We say: You can go do that but you can't get paid any more than X, and X doesn't go up unless we cause it to go up.

That is the reason for the fix that I proposed. It was in the amendment originally but then it was determined

that this had to be sunsetted. My amendment eliminates the sunset, allows the authorization for the pure competitive bidding to continue on. That is as simple as it is and is the primary reason why I did it.

Let me note a couple of other items. Some people, especially my friends on the Democratic side, have said, wait a minute here, this has to be balanced. And I said I agree. The drug benefit, according to CBO, right now in the bill, the underlying bill, is $402 billion over 10 years. It slightly exceeds the $400 billion. In the same bill we are spending $7.8 billion over 10 years on the PPOs and Medicare+Choice, which are the HMOs.

So it is $402 billion on the drug benefit, $7.8 billion on the PPOs and HMOs. I think we could afford to put a little bit more money toward ensuring that the PPOs can be successful here, that they will bid and provide these services to our senior citizens.

Another point: When we put these price controls on the providers, as we do today under Medicare, as I said, there is no free lunch. Somebody has to pay. What happens is that the private sector health insurance in our society is subsidizing Medicare. The hospitals and the doctors and all the other providers have to make it up somewhere and that is where they make it up. This raises the cost of private insurance. A lot of people find that very hard to pay. In fact, it takes some people out of the private insurance markets. So, ironically, one of the reasons not as many Americans are insured as should be is because the premiums are too high because the private sector has to subsidize the care that we are providing on the Government side of the equation through Medicare and Medicaid.

This price cap is going to further that subsidization, ironically at a time when millions of retirees are going to be leaving the private market because their employer will no longer want to provide a benefit that the Government is providing for at a taxpayer subsidy. So there is going to be a lot smaller private sector market to subsidize a lot bigger amount, which will cause more people to lose their insurance because of the higher cost of premiums. It does not make sense to underfund Medicare.

The final problem: Remember at the very beginning I mentioned the FEHBP, the Federal Employees Health Benefits Program. It is interesting that throughout the history of the FEHBP we have not had any of the problems I have been talking about here. Congress has rarely had to do anything to modify the FEHBP system. It works very well. Yet every year or so we have had to modify the reimbursement to Medicare providers in response to what we did through the Balanced Budget Act of 1997. We have had to do it ever since because we are not smart enough to know what every doctor in this country and every hospital ought to get paid to take care of us. Yet that is what we tried to say in the statute. So we have to keep changing it. Why would we want to not go with a system that we know has worked very well? We can do that by allowing this open bidding and allow the free market to work.

I think for all of these reasons it would be very wise for us to remove the sunset on the Grassley-Baucus amendment and let this process work, even a little bit, and show our colleagues in the House of Representatives and, frankly, all the country that we are committed to this principle of the free market ensuring the best deal for the American taxpayers but also the best deal for our senior citizens.

I am just going to close with this thought: Medicare is a mandatory system in the United States of America. There is essentially no option. When you are 65 years old, it is Medicare or no care. A doctor cannot take care of you outside of Medicare after you turn 65. There is only one exception, and that is if the doctor says: I will not treat any Medicare patients for a period of 2 years.

Now, we do not want to force our doctors into doing that. We want them to stay in Medicare, taking care of Medicare patients. But the only way a doctor can treat people outside of Medicare is to swear—there is a formal process for doing it—that he will not treat any Medicare patients for 2 years. We do not want them to do that, but that is the only way. You would have to find such a doctor. If your condition is diabetes, and that doctor is an orthopedic surgeon, you probably will not have too good of luck.

So most seniors do not have the option of searching around trying to find a doctor who works outside of Medicare because most of them do not do it. Fortunately, most of them stay in Medicare. But this is the only circumstance under which you can find a doctor outside of Medicare.

Since we are saying—literally mandating—that our moms and dads—pretty soon some of us—have to take the Government program for our health care after we turn 65—and nothing is more important to us than our health and our family's health—my mom's health—it bothers me a lot that we are setting up a system to take care of my mother that we know in advance is bound not to work. It promises a benefit it cannot deliver. But because of the scoring problem, we have to do it that way.

There is a better alternative: to take the time to do it right, to make the personal commitment to do it right, to understand there is no such thing as a free lunch—that I want to deliver the best quality care for my mother as I can because she does not have an option.

If she had an option to go into some other system, as they do in Great Britain, then I would not be quite as concerned.

But we are forcing everybody into a system, and then we are saying—as we tie its hands behind its back—now you make sure you can go out and serve, when CBO says only 2 percent of the people will sign up for that. So that means everybody is going to continue on with traditional Medicare.

Now, maybe that works for them, but we know there are going to be some huge problems not too far down the road with traditional Medicare. Are we going to be able to deliver the benefits we promised? If you look at the numbers, we are going to have big tax increases or we are going to have to go deeply into debt in order to do that.

There is an alternative, and that is this option I have been talking about. Because we are playing with real people's lives, and because the ultimate value here is the quality of medical care we are going to ensure our senior citizens get—because it is the only way they can get medical care—we have the highest obligation to give this matter our most serious attention and not simply rush it through because we want to finish the bill before the July Fourth recess—although I certainly understand the Secretary and our leadership's desire to try to do that to get the bill in conference—but to take enough time and to give it enough thought to do it right.

This is forever, in a sense. It is for a long, long time. And for those friends of mine who say, ''Oh, don't worry about it; we are going to make a lot of changes in this,'' how many changes have we made in some of the sort of ''sacred cow'' laws in the United States—things that everybody supports and so nobody wants to even suggest to change: Social Security, Endangered Species Act, Medicare itself?

It is easy to demagog these issues, and, as a result, Members are not very keen to make changes with them; you are accused of trying to destroy the program or whatever it might be. So I think my colleagues who say, ''Oh, don't worry; we'll fix it later,'' miscalculate the courage they are going to have later when they realize it has to be fixed.

The time to do it is now. The time to get it right is now. The President is right, this was the way to do it. And so, to support the President's program, I am offering this amendment to get back to what that program was. I hope my colleagues will support me in this because nothing less than quality health care for my mother and the rest of the senior citizens in this country is at stake.

Mr. President, I appreciate your patience, and I yield the floor.

Mr. ALEXANDER. Mr. President, I wish to voice my support for the inclusion of disease management as a permanent part of the Medicare fee-for-service program. I consider disease management a way to reform the fee-for-service program. I am concerned about the long-term fiscal viability of the Medicare program. As we add a much needed drug benefit to the Medicare program, we must do so in a way

that seniors can afford and that our country can afford. Consistent with a letter I signed to the President, I continue to look for ways that we can take this opportunity to reform the current program and ensure we keep the program strong for future beneficiaries.

I understand that the Medicare bill we are debating incorporates disease management as part of the new Medicare Advantage Program, so that private plans offer these services to beneficiaries and that there are several demonstrations to test out a variety of care management techniques in the traditional, fee-for-service program. That is a positive step in the right direction. But I think we need to go further.

I believe strongly that seniors will get better care in a private plan option under this bill, and I encourage them to do so. But I also know there will be seniors that choose to stay in traditional, fee-for-service Medicare. And these will likely be older seniors, the ones that do suffer from multiple chronic conditions and are in the most need for efficient management of their health care. I ask you, can we afford to allow these beneficiaries' health to worsen and to subsequently bear the enormous costs of their care? We cannot. I believe that adding disease management to the traditional-fee-for-service program is a way to reform the system, and to help bring down costs for these seniors. Disease management can reform the system to improve the long-term sustainability of Medicare.

Last week the House Ways and Means and Energy and Commerce Committees both voted in support of legislation that would incorporate disease management into all of Medicare—both private plans and the traditional, fee-for-service programs. I ask that as we move into conference, I hope we can accept the House language that phases in disease management as a permanent part of the Medicare fee-for-service program.

Without a doubt, it is critical to the health of seniors and to the pockets of taxpayers that we implement effective reforms such as disease management in Medicare now—to more rationally and effectively manage care for beneficiaries with chronic conditions, and to ensure the fiscal sustainability of the Medicare Program.

Mr. SMITH. Mr. President, I rise today with my colleague from North Dakota in support of critical drug coverage for beneficiaries who contend with the debilitating effects of multiple sclerosis.

This amendment would provide transitional coverage for the four FDA-approved therapies in the 2-year interim until 2006, when the prescription drug plan will take effect.

Approximately 400,000 Americans have MS. In my home State of Oregon, it is estimated that there are 5,800 people living with MS.

Currently, Medicare covers only one of the four FDA-approved MS therapies and only when administered by a physician. This amendment would cover all four MS therapies, including when they are administered by the patients themselves, providing better coverage and better care for Americans with multiple sclerosis.

While these therapies do not cure MS, they can slow its course, and have provided great benefit to MS patients. It is critical that MS patients have access to all approved drugs because some MS patients do not respond well to, or cannot tolerate, the one MS therapy that is currently covered.

Currently, many Medicare beneficiaries with MS are forced to take the less effective therapy, to pay the costs out of pocket or forgo treatment.

Equally, this amendment is important to rural Medicare beneficiaries with MS. By administering drugs themselves, rural beneficiaries can avoid the costs and hassles of traveling long distances to health care facilities to receive their MS therapy.

In the spirit of providing all Medicare beneficiaries with increased choice, MS patients need and deserve the full range of treatment choices currently available and self-administration helps ensure access to needed medications.

I urge my colleagues on both sides of the aisle to join me in support of this amendment and to provide adequate and comprehensive drug coverage for MS patients.

ADEQUACY OF MEDICARE PAYMENTS TO PHYSICIANS

Mr. SPECTER. Mr. President, I have sought recognition today to engage the distinguished chairman of the Finance Committee in a colloquy regarding concerns about the adequacy of Medicare payments to physicians.

Each year, Medicare payments to physicians are adjusted through use of a ''payment update formula'' that is based on the Medicare Economic Index, MEI, and the sustainable growth rate, SGR. This formula has a number of flaws that create inaccurate and inappropriate payment updates that do not reflect the actual costs of providing medical services to the growing number of Medicare patients.

As discussed above, the formula has resulted in numerous payment cuts to Medicare physicians. Earlier this year, Congress passed legislation as part of the fiscal year 2003 omnibus appropriations bill, H.J. Res. 2, that avoided an impending 4.4-percent cut in the Medicare conversion factor. This was accomplished by adding 1 million previously missed Medicare beneficiaries to the mix and recalculating the appropriate formulas. Although this change resulted in a welcomed 1.6-percent increase in the Medicare conversion factor for 2003, the Centers for Medicare and Medicaid Services', CMS, preliminary Medicare conversion factor figure predicts a 4.2-percent reduction for 2004. The reason for this latest reduction stems from the fact that the current formula that originally resulted in the need to fix the 2003 conversion factor cut, is flawed. The latest scheduled round of payment cuts will make Pennsylvania's Medicare practice climate untenable.

In its March 2003 report, the Medicare Payment Advisory Commission, MedPac, stated that if ''Congress does not change current law, then payments may not be adequate in 2003 and a compensating adjustment in payments would be necessary in 2004.'' We owe it to America's physicians to fix the system so that they can continue to provide Medicare beneficiaries with the vital care they need.

With 17 percent of its population eligible for Medicare, the Pennsylvania Medical Society has calculated that Pennsylvania's physicians have already suffered a $128.6 million hit, or $4,074 per physician, as a result of the 2002 Medicare payment reduction. If not corrected, the flawed formula will cost Pennsylvania physicians another $553 million or $17,396 per physician for the period 2003–2005. They simply cannot afford these payment cuts. I know you have worked very hard in preparing a bipartisan Medicare bill that represents a good solid beginning to improving our Nation's health care system. However, I firmly believe this is an issue that Congress must address.

Mr. GRASSLEY. Mr. President, I thank my colleague from Pennsylvania for raising this important issue. He is correct that I have been working with the physician community, as well as the U.S. House of Representatives, to obtain a fuller understanding regarding the adequacy of the current physician formula under Medicare. We have learned that Medicare's current payment formula for physicians is problematic, and I agree that this issue should be addressed. We will continue our discussion, and objectively evaluate proposals that will update the payment formula for physicians.

Mr. SPECTER. I thank the chairman for his willingness to work with me on this issue as the Prescription Drug and Medicare Improvement Act moves forward.

The PRESIDING OFFICER. The Senator from Missouri.

MORNING BUSINESS

Mr. TALENT. Mr. President, I ask unanimous consent that the Senate proceed to a period for morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

SALUTE TO THE 129TH MOBILE PUBLIC AFFAIRS DETACHMENT

Mr. DASCHLE. Mr. President, on July 12, the 5th U.S. Army will demobilize the 129th Mobile Public Affairs Detachment of the South Dakota National Guard. This unit, headquartered in Rapid City, was among more than 20 Guard and Reserve units from my State called to active duty in support